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Vol. X.

ATLANTA, GA., APRIL, 1908.

No. 1

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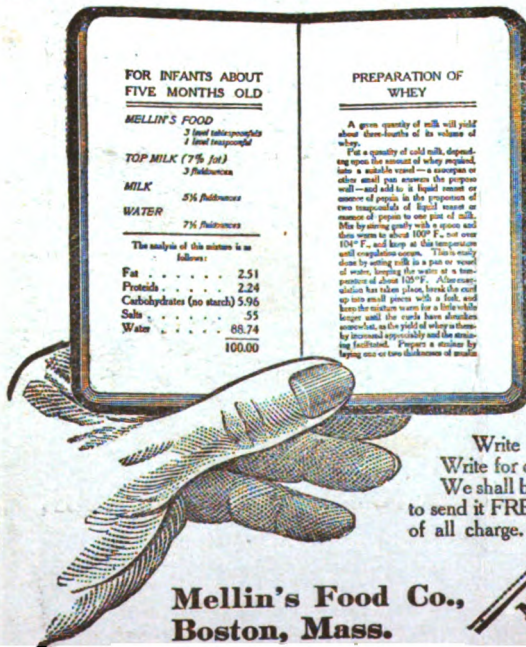
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## ORIGINAL COMMUNICATIONS.

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### REST IN THE TREATMENT OF BRIGHT'S DISEASE.

BY H. F. HARRIS, M. D., ATLANTA, GA.

The therapeutic value of rest must have been more or less appreciated even before the dawn of the medicine of to-day, but it was not until John Hilton wrote his masterly monograph on this subject that the especial attention of the medical profession was turned in this direction. Even Hilton, however, regarded the matter rather from a surgical than a medical aspect, and though the credit is due him that he first distinctly recognized and directed attention to this most powerful of therapeutic agencies, it is clear that he did not appreciate its value in the treatment of diseases of the internal organs. Somewhat later Weir Mitchell introduced rest in the practice of medicine as distinguished from surgery, and as the result of his advocacy this agency is now universally recognized as the most potent in correcting the curious nervous states that result from over work, or, what is much more frequently the case, from the various forms of indigestion. Notwithstanding the great degree of merited

favor, which the Mitchell plan of treatment has attained, it appears to me that the profession as a whole has not as yet appreciated the wonderful potency of rest in the treatment of disease-conditions generally. If I be correct in this view there is no question that we discard assistance of the most powerful kind in our combat with disease.

The experience of recent years has convinced me that one of the great faults in the treatment of that group of conditions known as Bright's disease has been the almost total disregard of the necessity of proper rest. This failure on our part to apply well known principles in this particular case has probably in a measure resulted from a rather indefinite idea as to the causation of the various kinds of chronic inflammation of the kidneys. We have been disposed to look upon these conditions being for the most part inevitable, and a consequence of mysterious agencies, the exact nature of which are entirely unknown. This feeling has been undoubtedly strengthened by the notorious failure of all ordinary therapeutic agencies in the treatment of this disease. It is true that we have long recognized that when patients are placed on milk—the best and most easily assimilable of all foods—they more or less improve, but even where this plan of diatetic treatment could be rigidly carried out, we have expected the patient gradually to go from bad to worse and ultimately die. The object of this paper is to suggest the combination of proper dieting with rest,—this, when properly carried out, appearing to me to promise more than any other method of treatment.

In order that we may at least have a theoretical understanding of the why and wherefore of the above suggestions, a brief consideration of the causation of Bright's disease may not be without interest.

It has long been recognized that during the course of any of the ordinary acute infectious diseases inflammations of the kidneys may supervene—in most cases quickly subsiding, but in others terminating finally in the chronic disease—conditions that we call Bright's; apparently the latter are of frequent occurrence. It should also be remembered that in some of those instances where Bright's apparently results from acute diseases, the patients have previously suffered from an unrecognized chronic inflammation of the kidneys, which are only diagnosticated after having been made worse by the acute malady in question. In



another class of cases we have long looked upon alcohol, lead poisoning, and gouty states as being etiologic features, but in this country, at least, it is only occasionally true that we can trace antecedents of this kind for instances of chronic Bright's. To what then shall we ascribe the production of these cases of Bright's that are clearly not the result of the supposed usual causes?

I am naturally averse to theorizing, and look upon with the greatest suspicion all conclusions established by this very questionable method of reasoning.

However, where facts seem to more and more square with our theoretical deductions as we look into a matter more closely, the time is finally reached when we may be authorized in putting forward tentative views, and such is my attitude in this instance. For many years it has seemed to me in the highest degree probable that almost all cases of Bright's disease are due to chronic "indigestion." I am unfortunately not in a position to absolutely specify the precise nature of the particular kind of imperfect digestion that I think gives rise to these inflammations. Indeed there can be no question that at the present time we possess no very accurate knowledge of the exact character of the different states that are quite vaguely known as "indigestion," and I believe that we can only hope for a better understanding of this subject from a patient chemical and bacteriological investigation of the intestinal excretions in these conditions. Certain assumptions, however, appear to me as being highly probable. Bright's disease seems much more common and the affection comes on much earlier in life in those persons who are of a corpulent tendency, and particularly where such individuals are rather free-livers. The comparative immunity of thin persons, it seems to me, may be a consequence of the fact that they are usually more or less dyspeptic, and that they generally find that overeating makes them much worse. I do not believe alcohol is very often directly responsible for Bright's, but I have frequently seen it occur in people who make a habit of taking a drink or two before meal times, or in those who drink wines or beer with their food. In both of these cases the alcohol probably acts in the way of producing an excessive and unnatural appetite, and, as a consequence, more or less indigestion occurs. It has long been recognized that persons who drink very excessively do not have gout, and my own observations point to the probability that

such individuals rarely have Bright's. The probable explanation is that unfortunates of this kind eat very little, and, as a consequence, do not have the chronic forms of indigestion occasioned by the excessive taking of food. Much of the clinical evidence in support of the view that Bright's results from some form of chronic indigestion is obtained from the urine. An examination of this excretion in the earlier stages of the affection will usually show it to contain, in addition to albumen and casts, an increase in indican and skatol, and the Ehrlich paradimethamidobenzaldehyde reaction is most pronounced. On microscopic examination we often find oxalates, and not infrequently uric acid.

If we now accept the suggested causation of Bright's, the first obvious deduction would be that patients should be placed on some diet that would, while being sufficient for all of the needs of the organism, be easily digested and assimilated. For this food we would naturally turn to milk, which, as we all know, has been regarded universally as the most efficient method of treating this terrible disease. To this accepted method of treatment, I would add rest, for what seems to me to be the following good reasons:

It is well established that a person at rest needs practically one-half of the amount of nourishment required while at active work, and we, of course, know that the functional activity of the kidneys depends upon the amount of chemical change that goes on in the body. It is not necessary to argue to the point that the diseased organ should have as much rest as possible, and if we can accomplish this by putting the patient at rest, limiting the amount of food and thus decreasing the work that the kidneys have to perform, these organs would be placed in the best possible condition for gradual restitution. Of course, I would not assume for a moment that a treatment of this kind could restore kidney tubules that are entirely destroyed, but the fact that the patient is living is evidence that those still remaining are competent to keep life going, and if we can put a stop to the further advance of the disease, the patient should be able to live out his allotted years.

Unfortunately this treatment requires considerable time, which makes the collection of statistics an exceedingly slow matter. I have seen a patient who had undoubtedly suffered from Bright's for a number of years previously apparently entirely

recover in eighteen months. In this case the urine was loaded with casts and albumen, and the patient just prior to the inauguration of the treatment had suffered two attacks of apoplexy, and a few months later had had a hemorrhage into the retina of one eye. I have another patient who has been on this treatment for about seven years, and although he had lost complete sight of both eyes at the time he was first seen by me, he is apparently now well in every other particular. For a number of years now he has not adhered strictly to the treatment. I have a number of cases at present under observation who have shown most pronounced good effects as a consequence of the treatment, and it seems to me that if it could be carried out thoroughly that our results would be infinitely better than they are at present. At this point I would say that under rest in bed and the milk diet the urine of patients frequently becomes normal in two or three months, but if they begin to take exercise or resume ordinary foods the albumen quickly reappears; the treatment should, therefore, last over a period of at least a year, and perhaps longer in most instances. When the patient begins to resume his ordinary method of living the urine should be frequently examined, and if evidence of trouble reappears the patient must again be placed on the treatment.

I believe that the rest treatment should be taken under conditions where the patient can get the maximum amount of fresh air. He should, of course, at all times be warmly clad.

I believe that a small dose of morphia daily materially assists in limiting tissue change, and can usually be given with advantage.

It is very important that the patient's bowels be kept open.

This communication is in the nature of merely a preliminary paper; at some future time I hope to give to this Association a statistical report of the results achieved.



## THE VALUE OF DETERMINING THE OPSONIC INDEX IN THE TREATMENT OF CHRONIC INFECTIONS WITH VACCINES.

BY J. EDGAR PAULLIN, B. A., M. D.

*(From the Laboratory of State Board of Health.)*

Recently an abundance of literature has appeared dealing with the practicability and feasibility of determining the opsonic index in reference to the administration of vaccines. There seems to be a considerable difference of opinion among most of the writers as to whether the time spent in going through the long procedure necessary to make this determination is worth the while, and as to whether it gives an accurate idea as to the exact state of the patient's blood. Perhaps it will not be amiss to briefly review some of the objections to this determination, and, at the same time, point out the fact that therapeutic vaccines can be, and are, administered without the tedious procedure of determining the opsonic index.

In a previous resume on opsonins (Medical Consensus, February, 1907) it was attempted to briefly outline the technique which was employed in the estimation of the index. In order to understand the sources of error, it perhaps is best to mention briefly the procedures ordinarily employed. As stated then, three solutions are necessary:

- (1.) An even bacterial suspension in normal salt solution free from clumps.
- (2.) Washed white blood corpuscles.
- (3.) Serum to be tested.

Regarding the white blood corpuscles, it is generally advisable that they should be corpuscles from the patient whose index is to be determined. We next prepare what Wright has fitly called a "pool of serum"—meaning by this, serum from four or five normal individuals. This is used for the purpose of comparing with the serum to be tested. Preparations are then made containing equal parts of serum, bacterial suspension and washed corpuscles. These are incubated at 37 degrees Centigrade fifteen minutes. Smears are then made and stained with some of the

aniline dyes,—preferably Hasting's solution. One then counts the number of bacteria contained in a certain number,—usually 50 polymorpho-nuclear white cells. In examining such a preparation one observes that not all of the white blood cells contain bacteria, so that we generally take into account the number of cells containing bacteria and those not containing bacteria. Comparing these results we observe what is called the phagocytic index.

The result obtained from the "pool of serum" is taken to be normal, while that obtained from the serum to be tested is compared with the "pool" and is considered to be either above or below normal, according to whether the leukocytes contain a greater or less number of bacteria than the supposedly normal one.

To one who has had experience with this particular technique, the sources of error are quite numerous. In the first place, perhaps the greatest source of error lies in what is called the "personal equation,"—a factor which cannot be eliminated from any of the determinations. This is very well illustrated by the accompanying table, which is a series of three counts made on the same slide by three individuals who had had considerable experience in this work. The bacteria were counted in 50, 100 and 150 leukocytes respectively, and the results recorded.

|                          | Bacteria<br>Within<br>50<br>P.W.B.C. | Bacteria<br>Within<br>100<br>P.W.B.C. | Bacteria<br>Within<br>150<br>P.W.B.C. | Lowest<br>Bacteria<br>Per Cell | Highest<br>Bacteria<br>Per Cell | Difference<br>Between<br>Highest<br>and Lowest |
|--------------------------|--------------------------------------|---------------------------------------|---------------------------------------|--------------------------------|---------------------------------|--|
| A's Counts .....         | 76                                   | 165                                   | 235                                   | -----                          | -----                           | -----  |
| A's Bacteria Per Cell .. | 1.5                                  | 1.65                                  | 1.56*                                 | 1.5                            | 1.65                            | 0.15   |
| B's Counts .....         | 87                                   | 150                                   | 268                                   | -----                          | -----                           | -----  |
| B's Bacteria Per Cell .. | 1.74                                 | 1.6                                   | 1.78                                  | 1.6                            | 1.78                            | 0.18   |
| C's Count .....          | 80                                   | 169                                   | 252                                   | -----                          | -----                           | -----  |
| C's Bacteria Per Cell .. | 1.8                                  | 1.69                                  | 1.68                                  | 1.68                           | 1.8                             | 0.12   |

From this table we observe that there is a considerable difference between the three counts. The highest number of bacteria in 50 P. W. B. C. is 87, whereas the lowest is 76 P. W. B. C. In the count of 150 P. W. B. C. the highest count is 268, while the lowest is 235. It is seen from this that a considerable difference of opinion exists in the minds of workers as to whether the given organism is within or upon the given leukocyte. However, if we take the three counts of the respective individuals and compare these counts with each other, we observe that the difference be-

tween the counts in 50, 100 and 150 cells is within the limit of error, and that the number of bacteria, as figured per cell, is practically the same in the three counts, so that it is necessary as a rule in determining the index to have all counts made by the same individual.

It is generally supposed that an error of from 4 to 8 per cent. even with an individual worker is to be expected, so that from the above table we see that the individual counts come within the limit of this source of error.

As recently stated by Park and Biggs (*Journal of Medical Research*, Vol. 17, No. 1, Page 77), the opsonic index is by no means a fixed quantity, even for a normal individual, and they have expressed the opinion which we have long held and several times demonstrated, that there is a fluctuation in the index of normal individuals varying with the time of day and condition of the individual, whether fatigued or at rest. This was shown to be true with reference to the staphylococcus aureus, and it might readily be supposed that such a condition is true relative to other organisms. As yet, however, not enough proof is forthcoming to establish this as a fact. Since this is supposedly true for the normal individual, it might well be a question if the same fluctuation does not take place in the serum of a patient the subject of a chronic infection. In fact, it would seem reasonable that these fluctuations would be more marked under these conditions.

The authors above referred to also point out the fact that we never know the opsonic index at the time of the administration of the vaccine. The reasons for this are very briefly stated, as follows: In the first place it is generally from three to twenty-four hours after obtaining the serum that we are able to arrive at a conclusion as to the index of the patient. This condition is true on account of the fact that it requires considerable time to estimate the index, and very frequently it is impossible to continue straight through the procedure after it is once commenced; since this lapse of time is necessary between the obtaining of the blood and the conclusion reached as to whether the dose of vaccine is necessary or not, supposing that it is necessary, the vaccine is administered on an index determined the day previous, and it by no means signifies that the index of the patient is the same at the time the vaccine is administered as it was when determined.



In the table, No. 2, which follows below, a series of indices were determined on three different patients, the subjects of chronic infections.

| Date                      | 19  | 20  | 21  | 22  | 23  | 24  | 25  | 26  | 27  |
|---------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Patient A., Opsonic Index | 1.2 | 1.0 | 1.3 | 1.0 | 0.9 | 0.9 | 1.1 | 1.3 | 0.9 |
| Patient B., Opsonic Index | 0.6 | 0.7 | 0.6 | 1.0 | 1.1 | 0.7 | 0.8 | 0.8 | 0.6 |
| Patient C., Opsonic Index | 0.9 | 0.8 | 0.7 | 0.7 | 0.6 | 0.7 | 0.6 | 0.7 | 0.7 |

From this table one notices that the opsonic index varies greatly in the same patient from day to day; these determinations were made before the administration of the vaccine in order to find out, if possible, whether the patient's condition warranted vaccine therapy. In two of the cases one observes that the index was persistently below the normal. However, it is noticeable that in one, patient B., the index on one occasion was normal and on the other above normal. It is perfectly conceivable that had these indices been determined only on these two occasions that those believing implicitly in the value of determining the index would not have administered vaccine, whereas, clinically, it was observed that vaccine therapy was clearly indicated.

From the foregoing facts we have in our work practically abandoned the determination of the index, and we are convinced quite firmly that by observing the clinical condition of the patient we are often able to determine satisfactorily as to whether the administration of the vaccine is necessary or not.

Our experience with vaccine therapy now amounts to something like fifty cases, in which we have administered vaccines without determining the index. These cases are those of tubercular lymph glands, tuberculosis of the bone, tuberculosis of the skin, furunculosis, chronic empyema, chronic pustular acne and chronic gonorrhoeal arthritis. In the greater number of these cases improvement has been quite marked, and we feel justified in stating that the administration of vaccines can be carried out as satisfactorily without the determination of the opsonic index.

### OBSERVATIONS IN 271 CASES OF MASTOIDITIS.\*

F. P. CALHOUN.

Mr. President and Gentlemen:

During my interne-ship in one of the large Ear hospitals of this country, I had occasion to assist in, or operate upon 271 cases of Mastoiditis, 49 of which I operated myself, and with this ex-

\*Read before Fulton County Medical Society, March 19th, 1908

perience, coupled with a number of operations I have made since my return home, I beg your attention to a few personal observations.

The cases of Mastoiditis under consideration were the acute variety, following an acute otitis, and the so-called Schwartz operation, modified or improved, was done; meaning a thorough ablation of the entire mastoid apophysis and surrounding cells.

Among the influences which played important parts in the causation of acute Mastoiditis, season was most important, for more acute ears were found during the mid-winter months, early summer, and changeable seasons, than at any other time. Age was also a factor of note, as about one-half of the total number were under ten years. The youngest patient was eight weeks, and the oldest was sixty-three years. The bacteriology of acute Mastoiditis, while a subject in itself, can be dismissed in this resume, by saying that the Streptococcus, or one of its family, and the Pneumococcus, were the exciting causes in over 95 per cent. of the cases. Experience has proven that a Streptococcus invasion is most dangerous, and it is usually quick and virulent; the Pneumococcus acts slowly as a general rule, and is not so severe, although in a few cases, acting similarly to the Streptococcus. The Streptococcus Capsulatus, an organism attracting much attention lately among Aurists, especially those bacteriologically inclined, is an organism of much treacherousness, and in northern climates acts slowly but destructively. The symptoms in these cases are mild, but its pathological scope is large. This one brief case will illustrate the working of the organism:

Three weeks before admission to the hospital, the patient, a man, complained of a fullness in his left ear, and consulted an Aurist, and the ear commenced to discharge a few days later. There was only a moderate amount of pain up to that time, when there developed mastoid symptoms. He was placed in the hospital for observation. His symptoms on admission were the usual ones for acute mastoiditis; a free muco-purulent discharge, a reddened beefy looking drum, a moderate amount of tip and antrum tenderness, and a temperature of one hundred and one. A bacteriological examination of the discharge was made after a myringotomy was done and found to be streptococcus. With five days rest in bed and appropriate treatment, all symptoms except the profuse aural discharge ceased, and the patient felt unusually well.

There was however, that same angry looking canal condition, with perhaps some oedema of the postero-superior canal wall. A second bacteriological examination was made, and the streptococcus capsulatus was found. An operation was advised solely on the bacteriological findings and the profuse, persistent aural discharge.

The operation revealed a decidedly disintegrated bone, and epidural abscess, and a large exposure of dura. The patient entirely recovered.

It might be of interest to note while discussing the bacteriology, that in all cases of erysipelas following mastoid operations (and such complications do arise in spite of all that can be done), the erysipelas occurred in patients whose aural or Mastoid pus showed streptococcus. It is my belief and contention that this is not a true erysipelas (one of contagion), but a superficial infection, and it should not excite the surgeons alarm.

I believe a bacteriological examination of the Aural and Mastoid discharge to be of an inestimable help in making a prognosis and in following the course of the disease.

It is often hard to assign true causes for Mastoiditis. Colds, infections following nasal operations, trauma, and the infectious diseases were most common, but in the vast majority of cases, no cause could be determined.

Patients sought medical advice, either on account of pain in the ear, in the region of the mastoid or its vicinity, aural discharge, fever or swelling. Any one or combination of these symptoms were present, or all combined. Generally, adults came on account of pain, and babies were brought on account of post-aural swelling. Chills, fever, sweats, nausea, vomiting and vertigo were not uncommon symptoms in uncomplicated Mastoiditis, and optic neuritis has been observed in small extradural abscesses.

Temperature was seldom normal, very rarely sub-normal, but usually between 99 and 101. Where a temperature was 103 or above, suspicion was at once aroused, fearing some complication. There were five cases which, on admission to the hospital, showed a temperature between 103 and 105, and four had Sinus Thrombosis, and one Meningitis and Brain Abscess. Swelling was present over or about the Mastoid in about 50 per cent. of the cases, and pus was found 88 times in 133 cases having swelling, and 54 of the 88 cases with pus were children under five

years. It is thus seen that one-half of the Subperiosteal abscess formation occurred in babies. Swelling was a symptom of Mastoiditis in infants and children, and was present in about 90 per cent. Swelling usually occurred as an early symptom in children and infants, as did the abscess formation, and a late manifestation in adults.

Palpation was the most valuable sign of Mastoid involvement, and even then in a few cases it was misleading entirely. The tenderest portion did not always indicate the location of the greatest destruction. The tip was a maximum point of sensitiveness in relation to the antrum and post tip in the relative proportion of 3, 2, and 1. Post tip tenderness usually indicates cases of long standing or great destruction of the mastoid.

Frequently cases were found in which there was no tenderness of the mastoid on palpation, yet an operation was indicated on account of the profuse continuous discharge, septic temperature or headache. Nervous hysterical women misled two good aurists in two instances, and perfect normal mastoids were opened.

Sagging of the postero-superior canal wall, considered by many a positive sign of Mastoiditis, and an operative symptom, occurred in 40 per cent. of the cases examined, although the majority of these cases were in infants with a sub-periosteal abscess.

The aural examination showed the usual appearances of an acute purulent ear: Red, bulging drum, with or without perforation, and the land marks generally destroyed. The discharge ranged from a scanty serous nature in early cases, to a thick, yellow purulent one in cases of long standing.

Facial paralysis occurred as a symptom in four cases; they were in cases of long duration, and this symptom was a late one. All symptomatic paralyses recovered after operation.

The question naturally arises what constitutes operative symptoms of Mastoiditis in the absence of cardinal signs. With headache, temperature, profuse aural discharge, mastoid swelling, and pain on palpation, there can be little doubt as to what should be done. Many cases have but little temperature, although considerable discharge and much tenderness; such a case of long standing would be considered an operative one. Again, there is no symptom but a profuse aural discharge out of proportion to the usual tympanic infection. Such a quantity of pus could only

come from a disintegrating mastoid, and with a microscopical examination showing *Streptococcus Capsulatus* in a case of six weeks' duration, I would operate.

Mastoid tenderness, while the most valuable of all symptoms, can not be absolutely relied upon, for in both cases of hysteria mentioned, this was the leading symptom.

Blood counts, with an estimate of the percentage chiefly of the Polynuclearleucocytes is at times misleading, and it, too, does not always give positive evidence. However, in an important case with doubtful operative Mastoiditis symptoms with one or two blood examinations, showing a Leucocytosis and a Polynuclear account of 79 per cent., or over, I would be inclined to operate.

In two cases of doubtful operative Mastoiditis, one of a *Streptococcus*, the other of a *Pneumococcus* infection, I would more likely wait 24 to 48 hours on the *Pneumococcus* than upon its more virulent kin.

In addition to what has already been said relative to signs and symptoms, the patient's general condition, his facial expression, has much to do with whether one should operate now or await events for a few days.

To my mind, it is not the question of how little or how much pus one will find in the Mastoid, but will the patient recover without operative interference; and in closing this part of the paper, I would say that no patient should be considered an operative one until a free Myringotomy had been made, and that is most difficult to do without general anæsthetic.

The Mastoid operation of to-day (the improved, Schwartze) is so different from the work of surgeons of ten to fifteen years ago, that it is not surprising that a number of cases did not recover, that cases were left with posterior discharging sinuses or chronic discharging ears. As it is, in this series of 271 cases, as reviewed by the writer, 73.30 per cent. healed, 10.30 per cent. were in a state of healing when last seen, 8.40 per cent. were unhealed and no evidence of a permanent cure, while 5 per cent. had healed, but their ears still discharging. 50 per cent. of the cases unhealed occurred in children under five years of age, due largely to carelessness and neglect by their parents after dismissal from the hospital.

This improved Schwartz operation, taking the place of the Wilde's incision and the mere curettment of the Antrum, had reduced the percentage of failures in one series that I had occasion to follow from 25 per cent. to 13 per cent. This could even be less if one's private statistics could be consulted.

This improved Schwartz operation, consisting in the total ablation of all diseased structure, including the removal of the tip, is almost universally practised, and credit is mostly due our American operators.

I have had occasion to follow many cases of operative Mastoiditis where the work was done in both extremes; from the most conservative, almost bordering upon a mere removal of a portion of the cortex, and a slight curettment of the antrum, to the very extreme—a total ablation. With but one or two exceptions, I have yet to see a recurrence or a failure in healing after a thorough operation.

The operation itself can be accomplished in any number of ways, best I think with these few instruments, viz.: the large gouge, to establish the initial groove; the Mathieu Rongeur, to remove the cortex, and the back bent round curette of Richards, to remove the soft cellular structure. In removing the tip, the muscular attachment of the Sterno-Mastoid should not be severed, or cut, but gently detached with its periosteal attachment. Less pain in the neck following operation, and less danger with secondary wound infections are the reasons.

Best results are obtained where the wound is packed with iodoform gauze, dressed on the fourth day, and redressed every other following day, unless otherwise indicated. Where dressings are left longer, granulations grow into the meshes of the gauze, giving the patient much pain and discomfort at the dressings. If the aural secretion does not subside in a reasonable length of time, the bulky ear dressing should be removed in part and the canal exposed and irrigated many times a day, otherwise, it might be a means of promoting a secondary infection, leaving a poste-



rior discharging sinus. From eight to ten weeks is an average time for an uncomplicated Mastoid wound to heal.

There are three post operative complications, that at times prove quite troublesome, viz.: Facial paralysis, treated by the galvanic or faradic current, and massage; impaired hearing and tinnitus occurring in 6.4 per cent. and 5 per cent. of this series respectively, treated by tympanic inflations and vaporization; and impacted cerumen, in a distorted or drooping canal wall in 13 per cent. This complication, while not serious, is an annoyance, and is most likely due to the traumatism to the canal wall during the operation, disturbing the normal outlets to the deep ceruminous glands.

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## EXCESSES OF MODERN TIMES AND THEIR RELATION TO DISEASE.\*

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BY MARION MCH. HULL, M. D., ATLANTA, GA.

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One of the most prevalent causes of impaired health in this latter day is the indulgence in one or more excesses. We frequently have various forms of disease resulting from this cause whose symptoms are so complex that to describe them in detail would almost exhaust the list of known symptoms. For instance, there occurs to my mind as being very prevalent conditions nephritis, paresis, and gouty or rheumatoid conditions. It is not our purpose now to present an exhaustive study of how these originated, but to suggest in one or more instances the underlying causes and their development, hoping that it will help us to avoid such conditions in the future, by removing the possible cause now.

Underlying all diseases are four essential causes, as follows:

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\*Read before the Fulton County Medical Society, Feb. 20, '08

Inherited diatheses, nutritive disorders, nerve reaction, and infections. Rarely does one of these occur alone, but more often a combination of two or more becomes operative, and disease is the result. For example, take a child born of tuberculous parents; it is entirely possible for that child to develop into the most vigorous manhood and never have a sign of tuberculosis, even though it has an inherited diathesis. Suppose, however, that about the age of puberty when the whole nervous system is under great strain to control the functions properly, when the whole nature is undergoing a revolution, the child should eat some food which is difficult of digestion, a nutritive disorder would ensue and the resistance of the child be lowered. Now suppose this child at the time is in contact with tubercular bacilli exhaled from the lungs of a tuberculous parent. During all these years he has been inhaling this infected atmosphere, but has not developed the disease; now, because of the nerve reaction above spoken of, the disordered nutrition, with consequent lowered resistance, the bacilli gain foot-hold in a favorable soil furnished by the inherited diathesis, and the disease results. Thus we see that all four of these essential causes frequently enter into the etiology of a particular disease.

Of these four causes, however, what most concerns us in our present study is the influence exerted by nutritive disorders and nerve reactions. I propose to limit our discussion to two particular diseases which are very prevalent, and of which, I feel convinced, excesses are very prevalent causes; I refer particularly to arterio-sclerosis, with its multiform manifestations, and gouty affections. Take for instance, arterio-sclerosis; it consists essentially of a degenerative condition of the arteries of the body, the elastic fibres at first undergoing a fatty degeneration, weakening the walls and subsequently a sclerotic or hardened condition taking its place, the normal resilient tissues being replaced by non-elastic tissues. Now various symptoms may result from this, depending upon the degree of sclerosis and the location of it. Should the arteries of the kidneys be affected,

the symptoms of nephritis would result. An improper elimination of the products of metabolism which should be excreted by the kidneys would bring on a train of symptoms, which might produce subsequent heart or mental disorders. Should the arteries of the brain be affected, apoplexy would result, with immediate death, or hemiplegia with local softening of the brain; or paresis, might result with all its attendant train of symptoms. If the arteries of the heart should become affected, severe attacks of angina pectoris might follow. So you see that underlying a great many diseases is this condition of arterio-sclerosis.

Most authors in writing on this subject, assign as the principal cause alcoholism or syphilis. Of course, these diseases may, and undoubtedly do, produce arterio-sclerosis; but it has been my experience to treat a great many cases in which neither of these causes could be assigned; in fact, 90 per cent. could not be traced to either of them. In trying to account for the conditions, I have come to the conclusion that excesses of eating and of working, have been more responsible for them than the worship of Bacchus and Venus. Take for instance, the matter of over-eating; we all over-eat; it requires an amount of food which will furnish three thousand calories to supply the demands of the body for twenty-four hours, and this should be in the proportion of about 100 grms. of proteid, 600 grms. of carbo-hydrates, and 60 grms. of fats. This would be furnished by about four ounces of meat, or three glasses of milk and two eggs; about six to eight thin slices of bread, an ordinary serving of potatoes and rice, a dish of cereal morning and evening; an ordinary portion of butter at each meal; and from six to eight glasses of fluid in the twenty-four hours. A cursory glance at this will show in a moment that we ordinarily eat too large a proportion of meat, drink too little fluid, and eat too little fruit; and on the whole eat a great deal more than is required. The effect of eating too much would be to require the system to do more work and the eliminative organs to overtax themselves in their attempt to get rid of the products of metabolism, which should be excreted. Where exercise is deficient the organs are not able to eliminate these products, and a general accumulation takes place. These poisonous products circulating in the blood have the same effect on the cells of the body as the poisons of alcohol or of syphilis. The cells forming the arterial walls are

fed by food laden with poisonous products; degeneration takes place, followed by sclerosis. In this way, excess in eating may cause arterio-sclerosis, which may manifest itself in nephritis, apoplexy, or paresis. This is not mere theory. I recall now, a case of a gentleman who was most temperate in every respect except in the matter of eating; he was an enormous eater, and died of apoplexy after a few hours illness. There was no other way to account for the sclerosis in this case, except as above. I have also in mind a number of cases of nephritis which cannot be traced to any other origin. It is a matter of common knowledge that excesses in eating cause gouty conditions; so frequently is gout associated with the rich and overfed, that we have commonly supposed that it could not occur in the poor and underfed; which, however, is an error. In these latter, however, a different series of phenomena account for the error of metabolism.

Another one of the excesses which is extremely common and which is a very prevalent source of disease, is mental excess. By this I do not mean an excess of mental work only, but worry associated with work. Work wearies, but worry wears out. The fierce competition of modern times and the over-weening desire to augment wealth has developed a condition of high tension, that eventually results in disease of this character. Let us see how this comes about; a man now-a-days gets up, dresses hurriedly, eats his breakfast in haste, not chewing his food properly and frequently at the same time planning his day's work, withdrawing the blood to the brain from the digestive organs where it is needed for proper functioning; he hurries forth immediately after eating, and plunges head-long into a rush of work. At lunch, tired and with deficient nerve power, he hurries home, and through another meal in the same fashion, and back to his desk. Then when evening comes he is very much exhausted, and not able to properly digest the food which he ingests; and going to bed with his business on his mind, is fortunate if he is able to rest quietly. The next day the same round is repeated. If he is of that happy disposition that enables him to accomplish his work without worry, he is able to stand this exhaustive demand for quite awhile; but there are very few men who have that gift, and the little worries wear out the already over-taxed nervous system. Then the element of nerve reaction comes into play, and with insufficient nerve power, nutritive disturbances result,

with increased formation of the products of metabolism, and decreased elimination, with consequent defective nourishment of the cells, with degenerative conditions, and sclerosis. This is not purely theoretical either; for I have in mind at the present time several cases of this condition.

When we have advanced thus far, we have shown that the excesses in eating and in mental work with worry, are capable of producing disease, and we have shown how and why they do. It is not necessary to demonstrate that the more common and vulgar forms of excess would develop disease conditions; so that we are prepared to take the next step—how it may be prevented. I would suggest, first, that we can be more frugal in our meals than we have been in the past. I was recently at an institution where I had the pleasure of being thrown with a company of as fine a lot of men physically and otherwise as it has been my pleasure to see in many a day. Their breakfast consisted of a cup of coffee and of a bowl of oat meal, bread and butter, and boiled mutton; their dinner of chicken, baked potatoes, bread and gravy, and stewed fruit; and their supper of crackers and milk. Comparing this meal with what we ordinarily indulge in, and comparing the vigorous physique of these young men with that of the pampered rich, we can but feel that the advantage is in favor of frugality; certainly from an economical standpoint it would be so. Another thing we would learn would be that less worry and work would accomplish the same thing, if we combined with it a third suggestion, that I should like to make, that there should be more time given to outdoor exercise and recreation. I believe a revolution would be worked in the health of our community, their lives would be prolonged and life made more joyous if a specified time would be given to recreation and rest. The outdoor exercise would stimulate the excretory organs and improve the metabolism so that the various functions of the body would not be taxed beyond their powers. The nervous system would be better, and improved health would result. I furthermore believe, that with the general health improved, a larger amount of business could be accomplished in a shorter number of hours; and instead of financial loss resulting from the time given to recreation, financial gain would be the result. This lesson is particularly necessary for us in the South, at this time, with its marvellous material development. We

have attempted to keep up with its progress, but have not yet learned the secret of working intensively for a short time and stopping. To illustrate; in Atlanta, the average business man is in his office at seven-thirty and works until six-thirty or seven in the evening at least, crowding in every hour with its full quota of work; in the Northern cities, scarcely any one is in his office until nine o'clock and by four or five the offices are vacated. He works as intensively while he is at the office as does the alert Atlanta man, but he does not work as long; he has learned better how to take care of himself. I think enough has been said now to present my case; my plea is for a readjustment of our life and recognition of what the body requires, what its capabilities and possibilities are, and that we give the individual self a square deal, not expecting more work than God required of it to perform. I believe that the present rate of living is developing an increased number of cases of nephritis, arterio-sclerosis and rheumatoid conditions; it is time that we called a halt.

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ADDRESS OF C. B. BOOTHE, PRESIDENT OF THE CALIFORNIA ASSOCIATION FOR THE STUDY AND PREVENTION OF TUBERCULOSIS

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AT ANNUAL MEETING, DECEMBER 3, 1907.

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When big battleships begin to maneuver, they find it convenient to use a small gun to get the range. My duty here is simply to bring you within range of the real fighting forces in this warfare, and I shall engage but a very few moments of your time, for some of our big guns are here and ready to be aimed at you.

I know of no more appropriate introduction of what I shall have to say in this beautiful edifice, dedicated to God, than to quote from His word certain paragraphs, which indicate that the warfare in which we are engaged for the benefit of humanity, for the protection of our homes, firesides and loved ones, was being waged at the dawn of written history.



We have reason to believe that those nations who have lived largely in the open air and pursued out-of-door occupations, have to a considerable extent, escaped the excessive ravages of this disease, which flourishes in thickly settled communities among those who have indoor occupations, or dwell in unhygienic environment.

While the laws given in that greatest and oldest of law-giving Books, Leviticus, are both religious and ceremonial, they are also civil, moral and sanitary; especial stress being placed upon cleanliness and sanitation.

In the 16th verse of the 26th chapter, God is quoted as speaking to the children of Israel, and saying to those who would not harken to Him and do His commandments—"I will do this unto you; I will appoint over you terror, consumption, and a burning ague, that shall consume the eyes and cause sorrow of heart." And in Deuteronomy, the 22nd verse of the 28th chapter, the blessings of obedience and the curses for disobedience are set forth, and the first and most dreadful curse for disobedience of His laws is stated as follows: "The Lord shall smite thee with a consumption, and with a burning fever, and with inflammation and with an extreme burning, etc."

While Deuteronomy means the second giving of the Law for a generation yet unborn, and covers the period only of the last month spent by the Israelites on the plains of Moab, just before entering Canaan, at the end of the forty years wandering, it is in the 19th verse of the 30th chapter that is found the real secret of the book, in these words: "I call heaven and earth to record this day against you, that I have set before you life and death, blessing and cursing; therefore choose life, that both thou and thy seed may live."

If you will recall that the great leader, Moses, and many of those still with him, had come out of Egypt, and he often refers to pestilence and deadly diseases which were common there, and that he promised exemption from the Egyptian susceptibility to disease if they followed the laws which he set forth for them, it may well be believed that Tuberculosis, or Consumption as it is frequently called, had become a "terror" in the eyes of Moses while he lived in Egypt, for he graphically describes it; and it is believed that this disease did much to depopulate that land; and furthermore, one of our prominent scientific

investigators has recently advanced the statement that the tidal wave of this dread disease, which has occurred in various sections of the world, is due to the shipment and exposing of mummified human bodies, incident to the remarkable excavations carried on in Egypt and thereabouts; it being noted that the alarming spread of the disease had been co-incident with the exhibitions of these mummies from the ancient tombs. If there had been any great incursion of tuberculosis during the intervening time, I am unable to say, but during the last generation or two it has gained enough headway to cause scientific men to grapple with it.

England was the first country to recognize the necessity of better hygiene in homes, and the first nation to establish hospitals for those suffering from the many forms of tuberculosis.

In 1863, Parliament enacted a law governing the hygienic construction of houses. This was followed by laws demanding better workshops and sanitary homes for the workers.

A national association for the prevention of tuberculosis was formed in 1899, with the Prince of Wales as President. It has grown steadily up to the present time. In Great Britain there are about seventy establishments for the care of consumptives, the majority being for paying patients. There is still great need there for providing accomodation for the poor consumptives.

About 1896, in Germany, 800 distinguished citizens formed an association, of which the Empress is the Protectress, Chancellor von Bulow, the Honorable President, and General von Pannivitz, the Secretary. This association began the work of erecting what is called "Folks Sanatoria" or "People's Helping Stations," and this work has progressed so earnestly that now there are over 200 of these institutions in full operation, and between 12,000 and 14,000 tuberculous patients are continuously cared for in this way.

In 1899, a Congress was held in Germany to consider the subject of tuberculosis, which served to popularize the prevention of it among the poor.

As early as 1859, Dr. Brehmer, of Silesia, wrote several articles on the sanatorium treatment of tuberculosis. For a long time these articles remained unnoticed, both in Europe and in this country, but came finally to be recognized as the basis upon which the "open air treatment" of this disease is carried out all over the world.

Dr. Brehmer demonstrated by actual experience that "a life spent entirely out of doors in any kind of weather, good and abundant food and rest and discipline," are the chief requisites to utilize to bring about a cure.

Germany undoubtedly has the most numerous institutions for the relief of poor consumptives; they are also the best organized, showing the most definite results of any in Europe. Perhaps it is not too much to say that the world is indebted to Germany, and Germany to Drs. Brehmer and Dettweiler above all others, for the establishment of these sanatoria, Dettweiler having founded the first sanatorium for the poor at Ruppertshain. His sanatorium at Falkenstein is known as the mecca for students of phthisiotherapy from all over the world. Quoting from a tribute recently paid to Dr. Dettweiler—"He was a charitable man of unusual cordiality and kindness, yet strong in personality, stern and severe when occasion demanded it. He studied the whole life of every patient and was friend, confessor and physician."

I may take this opportunity to say that Dr. Dettweiler received his impulse and faith in the sanatorium treatment of consumption from Dr. Brehmer, whose patient he was for several years. Likewise, from Brehmer, came the inspiration to Dr. Trudeau, who, some twenty years ago, established what has grown to be a magnificent work at Saranac Lake on similar lines, and from Dr. Trudeau radiated the inspiration to our own Dr. Barlow, who has laid the foundation of an institution filling a distinct need, which has already been able to confer great benefit upon many indigent consumptives and promises for the future continued splendid work.

France, so far, has not done much for the tuberculous adult in providing sanatoria, but has directed her efforts mainly to the establishment of dispensaries in the midst of her most populous cities with very satisfactory results. There are a few isolated sanatoria in France, but the principal effort seems to have been to combat the disease in childhood.

Austria has also a number of sanatoria, the one best known being at Alland, some sixteen miles from Vienna, but this institution is only available to men in the early stages of the disease.

In Switzerland there have been established many sanatoria, reported to be well organized and showing excellent results.

Berlin can point to nine outdoor camps, six being for consumptive patients, the others for scrofulous cases and anaemic children. Schools are maintained in connection with these camps. The day should be hastened in this State when such outdoor camps are established, as they can not but be of great value, not only for immediate relief, but for the education which is radiated by way of getting a better understanding of health laws and the value of direct sunshine and fresh air.

Before referring to what has been done in our own country, I desire to mention that the Central International Bureau, made up of members from all nations, with headquarters in Berlin, established in 1902, is kept informed through correspondence of what is being done in all parts of the world as to the best methods for the prevention and cure of tuberculosis, and the information distributed from that Bureau is looked upon as authentic and of great value.

Other European countries have done something, but those above noted have reached the stage of the greatest effectiveness.

Up to two years ago, when the National Association held its first annual meeting, there were definite state societies in New Hampshire, Vermont, Pennsylvania, Maryland, Ohio, Indiana and Illinois. During the past two years new organizations have been organized in eight states—New Jersey, Delaware, North Carolina, Georgia, Kentucky, Minnesota, Iowa and Washington. Missouri, Rhode Island, Wisconsin, New York, Virginia, Michigan and California have plans well advanced, some of them practically completed. Several large cities like Boston and New York have each a local society, acting as a stimulating center for work in other communities of the State.

The census of 1900 shows 38 cities in the United States with a population of over 100,000. Up to two years ago, fifteen of these cities had organized societies for the prevention of tuberculosis. During the past year, in 11 additional cities, associations have been organized, and of the remaining 12, 7 have organizations under way, leaving only five unawakened.

You will hear this evening from Dr. Rupert Blue, who will, I hope, tell you something of the sanatoria established by our government.

Time will not permit me to give more than general data on this subject, but it may be broadly stated that every part of the

United States has received an awakening touch and the most important centers have responded energetically. In a large number of smaller communities, organizations have been formed and thousands of people have been aroused to the necessity of active co-operation in stamping out the disease.

The Fifth International Congress on Tuberculosis will be held in Washington next autumn, from September 21st to October 12th. This is the first time this Congress has arranged to meet in this country and it may not come here again in a generation. Official delegates will be present from almost every country in the civilized world, and the interest of the Federal Government has been enlisted. All of the departments of the government, excepting two, the Attorney General's and the Postmaster General's, have signified their intention to participate and have petitioned Congress for the necessary authority and means, while most of the Governors of the states have taken official action. There will be a course of thirty official lectures, which all members of the Congress and the general public are invited to attend; but the main value will be in the expert discussions and the more general intimate comparison of experiences and opinions among those who will constitute the regular membership of the gathering.

In California, through the initiative of Dr. F. M. Pottenger, this Association was organized in 1902. Dr. Pottenger was its first President. He was succeeded by Dr. H. G. Brainerd in 1905, and a year ago a layman was selected with a view of securing the co-operation of the general public, by divesting the League of the appearance of being purely a medical association. Under the auspices of the League, has been carried on an intermittent educational work mainly by Drs. Pottenger, Browning and Kress. During the past year, others have been enlisted in this work, as will appear in the report of the Secretary, which you are to hear later.

The Health Officers of Boards of Health, have, in many localities, identified themselves with the work of the League and given efficient direction and aid to our efforts.

A beginning in remedial legislation has been brought about through the efforts of the League in conjunction with the State Board of Health, in the enactment of a law requiring reporting and registration, not only by the medical profession, but by all to whom knowledge shall come of a case of infectious disease.

This law is coming slowly to be understood and complied with, but copies of so much of the Act as refers to this matter should be printed and distributed in every community in the State. There are some details yet to be worked out before this Act becomes as effective as it should.

In the early summer of 1906, a committee was appointed by the Board of Directors of this Association, to establish a Helping Station in Los Angeles where patients might be examined, the status of their cases determined, and such relief given as possible. Dr. F. M. Pottenger was appointed Chief of Staff, and in his absence, Dr. C. C. Browning was made acting Chief of Staff, with Drs. Kress and Thornton as assistants. These men have all given of their time and services freely, and with the aid of a Station Nurse and Visiting Nurse, 246 patients have been cared for up to date. The value of such an institution in the community, therefore, has been unquestionably demonstrated. I may say that no funds of this Association were used in this work, 16 men of Los Angeles having contributed \$775.00, of which about \$725. has been expended through the Helping Station.

When there shall be a real awakening in the public mind to the vast importance to the community of stopping the fearful waste of life caused by tuberculosis, then our public spirited men and women will come forward, with, at least, as much zeal as does the hog rancher, the cattleman and the orchardist, when cholera, anthrax, or one of those pests which do such damage to the orchards, comes upon him. In either event, neither money nor effort is spared until the infection is rooted out and the property saved from destruction. I will ask you to consider that the average value of a hog on the hoof is only \$14.00, and the average value of a steer, or a tree, is from \$40. to \$50., and that the loss annually by tuberculosis in the human family in the United States of 150,000 persons, at the average age of 35 years, a reliable authority claims is a loss to the community, based upon the net value of a year of human life at the age named, of not less than \$240,000,000 per annum. To this, must be added about a million and a quarter cases of tuberculosis existing in the United States all the time; one fourth of these must be supported other than by their own efforts, and where they are heads of families, wives and children dependent upon them must be cared for. The loss of wages alone which should be earned by this one-fourth incap-

acitated, at the rate of \$1.50 per day, figures out \$140,000,000 a year. All this to be added to the loss by death, which can not be measured in money value, nor the heartaches, sorrow, misery and distress entailed by this disease, the most insidious and the most difficult of detection of any. Tuberculosis is the great life extinguisher—it destroys more lives, two to one, than all the wars in Christendom. One seventh of all the deaths in the civilized world are caused by tuberculosis. Over 4000 deaths from this disease in California were reported in 1906. Some statistics which I have gathered show that but a very small percentage of these deaths are natives; 10 percent. had lived here less than three months; 25 percent. had lived here less than one year and 60 percent. less than five years. Does this statement suggest to some one that measures should be taken to exclude these bacilli laden people from our State? Let me take a stereoptican and throw on a screen a map of California and have it large enough so there could be shown every house, and over each house that contains a sufferer from this dread scourge, float a cross, who is there in this State brave enough to suggest that each one of those families should be turned back or blotted out? Some of the fairest men and women of this fair land have taken hope and courage for the fight against this dread disease under our sunny skies and amidst our evergreen groves, near the shadow of our mountains; cheeks that were wan have received the color of health, limbs that tottered have become strong, and health, life and joy have taken the place of woe and distress. These men and women have taken their places amongst us in all walks of life, carrying their full burden of responsibility, and contributing of their regained strength to the upbuilding of the Commonwealth. There is, however, some reason for restrictive measures to be taken in connection with the prevalent practice of communities in other States, sometimes by the advice of doctors, and frequently without it, sending to California the indigent invalid, tuberculous or otherwise, and treating this State as an organized county farm, or National Charity Hospital. We can not deny them our climate, or our fair fields; but if any community wants to avail itself of these benefits, it should be required to pay for the necessities of life required by those of whose support it has relieved itself, until they shall be able to take care of themselves.



In a book recently published, written by a most profound thinker and a student of Oriental art, a Japanese, a quotation is made from one of the early Chinese writers and philosophers—Soshimon—as follows: “The true beauty of a city lies rather in the happy faces of its people, than in the towers and ornaments upon its buildings.” If we all agree that this is true, shall we not consider it to be our first and chief duty to co-operate with any agency which has for its primal object, the conservation of the health of every individual in the community.

In such a simple statement may be embodied the aims and purposes of the California Association for the Study and Prevention of Tuberculosis.

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### HYPOSSPODIAS—PSEUDOHERMAPHRODITE.

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BY EDGAR G. BALLENGER, ATLANTA, GA.

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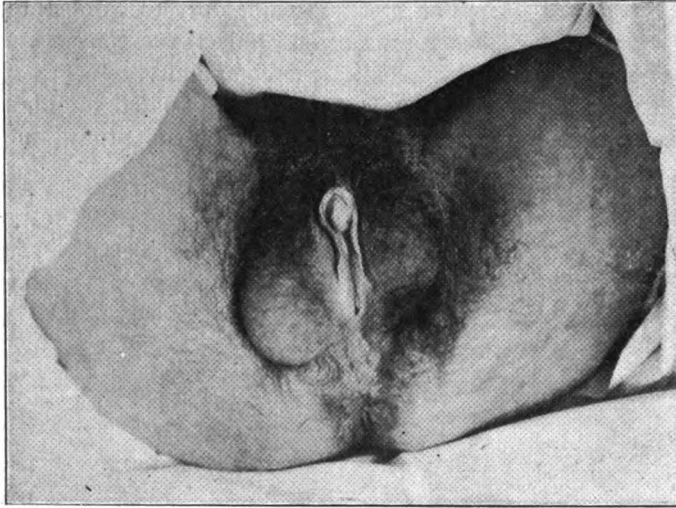
The accompanying cut. shows an interesting case of pseudo-hermaphroditism which has recently been viewed by a number of physicians and medical students of Atlanta.

The patient, who was referred to me by Dr. Bernard Wolff, for demonstration at the Fulton County Medical Society, gives the following history: Miss (?) S. H., aged 39 born in North Georgia, at birth was more like a girl than boy and consequently was dressed like a girl, and has continued this form of dress although there are no female sexual organs, the uterine and ovaries not being palpable.

About the age of 17 or 18 the patient claims to have noted a slight enlargement of the breast, and that menstruation was observed three or four times soon after; this was not accompanied by any pain. There is more sexual desire for men than for women. Sometimes has “spending dreams,” dreaming of coitus with a man. Less frequently dreams of having intercourse with woman, but something always seems to interfere with or interrupt the consummation of the act before orgasm is reached. Masturbation is indulged in several times a week—this may be done either as a male or female, there being little difference in the

sensation. The penis is about one and one-half inches in length, but when erect becomes two or three times this size. The sinus forming the pseudo-vagina is about three inches in depth. The urethral canal opens just within it on the anterior wall. The

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testicles are well developed and situated on each side of the labia in a rather loose pouch of skin or scrotum. The epididymes are of normal size and the right one contains a small nodule which is the remains of a previous epididymitis. (There is no history of specific infection.) By rectal examination the prostate could be felt as two nodules—one on each side of the urethra. The one on the right is round and about the size of a hazelnut; that on the left is flattened and apparently a little smaller. There seems to be no connection between these two lobes. No uterus tubes or ovaries could be detected by careful rectal examination.

The patient is tall and slender; no beard, but long hair of medium texture; the voice reminds one of a woman rather than a man. The general health is good, and there is nothing unusual or of interest in the past history.

## SPRING COUGHS.

BY JAMES BURKE, M. D., MANTOWAC, WIS.

It is irrational to treat a cough with opium or any of its derivatives, unless the several principles of which the opium is composed are isolated and available; then, it is possible one of these principles is antagonistic to (chemically affinitive for) one of the dominant disturbing toxins causing the cough; if so the neutralization of that disturber is at our scientific command.

The habits and environment of the coughing person will aid us in determining the dominant toxins actively producing the bronchial irritation. The cough is the result of the chemical attack of a toxin on the tissues of the lung, and especially on the structure of the nerve supply, in its metamorphosis of passing through the several stages of its cycle till it arrives by slow processes at the status of a benevolent excretory product.

This chemical worry of the lung cells catolyzes those cells, so that their secretory and excretory products are changed—pathologic—and by contact with neighboring cells, induce in them a retrograde product both of secretion and excretion, creating abnormal affinities, even extending into the volume of the general circulation.

Things in rapid progression leads to serious deterioration of the condition of the blood and fluids; early neutralization of the initial disturbing toxin would be "a stitch in time." Sajons has demonstrated that the pituitary body presides over and governs the balance in maintaining health in the natural order of metabolism, and in safeguarding the system in time of peril from autotoxins, bacterial infections and their toxins; the pathologic invader must be in solution in the blood in order that the special sense function of the anterior pituitary may detect its presence.

Through the posterior part of the pituitary body through special nerve connection, the adrenals thyroid and pancreas are given a rush command to increase their output; the adrenals to increase the adrenopidase, of which hemoglobin consists to ninety-four per cent. of its volume. Oridase is also the active principle of life, whose presence alone energizes the systemic cellular system; the thyroid furnishes the opsonins; the pancreas furnishes the trysin necessary for the energized leucocytes to encompass the bacteria and toxins, and convert them into living granulations

in harmony with the needs of the tissues, in their momentary distress.

Early neutralization of the toxins by giving affinitive, cognate vegetable principles will obviate a formidable array of the immunizing forces; these are thereby preserved for the normal balance of approaching health.

In all forms of chronic disease the immunizing power of the system has been overworked; the leucocytes are starved and unable to revert and synthesize the bacteria, toxins and leucomains into pabulum useful for the transmutation into normal tissue—they are mere carriers of bacteria and toxins, without the ability to aid in normal function.

In this complex condition of chronic invalidism the immunizing power is in abeyance, and science must come to the rescue, before the integrity of the sick cells become destroyed.

Therapeutic interference must convert the abnormal amino-acids of the badly digested protein, and more virulent toxins, into benevolent excretory products by administering the indicated alkaloids and other available active principles.

The cough may have originated from one of the many sources of production of auto-toxins. Start at the beginning, correct bad metabolic habits by relieving the functional cellular defect; re-establish normal alkalinity of the blood, by the proper use of calcium salts; interdict the ingestion of carbo-hydrates till the pancreas recuperates sufficiently to properly digest them, and to furnish trypsin to normally revert proteid food, and to enable the leucocytes to digest bacteria and toxins.

## CORRESPONDENCE

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Editor Journal-Record of Medicine,  
Atlanta, Ga.

Dear Sir:—

Have just received a copy of the Journal, the first I have seen, and I note what you say in regard to driving charlatans out of the State.

I know that the quacks of all descriptions can be eliminated if each physician will realize that he has a certain amount of this work to do individually. The trouble is, we depend too much on

each other and forget that we have something to do ourselves.

I am writing you, not exactly on the line of "quackism," but for humanity's sake as I see it. And you might say this will to some extent eliminate some of its practices or cut off one of the biggest inroads to patent medicines, etc.

You will find enclosed the bill as drafted by Dr. Izlar and myself last year. This bill was tabled for lack of support, or our Senator, Hon. G. W. Deen, withdrew it because of opposition.

I am informed that when this bill came up in the committee room Drs. Harris and Hardiman opposed it. I feel sure if these doctors only knew the condition which exists in the rural districts they would have been heartily in favor of it.

Now, if those who oppose this bill could only have half the experience the country doctors have had, they would be astounded that something had not already been done before now in behalf of these poor women.

Just think of it. The State of Georgia went crazy last year over prohibition and the bill passed. But when a bill was offered for the protection of the women in the rural districts, where hundreds of them die every year in confinement and blood poison as result of same and on account of witchcraft, superstitious old ignorant women, it was turned down.

Doctor Editor, I wish that you would figure a little on this and satisfy yourself on these facts. In the month of February I was called to see three cases of Puerperal Convulsions, one of which died. Convulsions all due to a kidney trouble and no physician had seen either of them until convulsions set in. Couple my experience with that of every doctor in the State and see how many deaths you have annually from this cause.

I want to say further that this bill is not intended to make the midwives stand an Anatomical and Obstetrical examination, for this we know they can't do or ever will do, but to make them amenable to law and to teach them things they should know, thereby preventing many deaths and diseased women, which is attributable alone to their ignorance.

We will greatly appreciate any assistance you can give us in behalf of this worthy cause.

Yours fraternally,

A. Fleming.

P. S.—This bill has been approved by the Ware County Medical Society.

## A BILL TO REGULATE THE PRACTICE OF MIDWIFERY.

Entitled, An act to regulate the practice of midwifery in this State by others than practicing physicians; to impose certain duties upon them; to provide penalties for the violation of the provisions of this Act; and for other purposes.

Section 1. Be it enacted by the General Assembly of the State of Georgia, and it is hereby enacted by authority of the same, that from and after the passage of this Act, all persons desiring to practice or engage in the art or practice of midwifery in this State, shall first obtain a certificate authorizing them to engage in such practice from the President and Secretary of the local Medical Society or Association of the county of their residence, if such exists in said county; and if there is no such Society or Association in such county, then they shall obtain such certificate from the nearest local Medical Society or Association accessible to them. Such midwife shall thereupon before commencing to practice, register in the office of the Clerk of the Superior Court in which he or she resides in a book to be kept for that purpose, his or her name, age, residence, place of birth, and the name of the Medical Society or Association from which he or she holds a certificate as aforesaid, with the date of same. Such certificate shall be first exhibited to the Clerk who shall be satisfied of its genuineness before the applicant shall be permitted to register. The Clerk shall indorse the word "Registered" upon said certificate, signing and dating the entry, and he shall likewise sign and date the entry of registration made in the registry book, as above provided for. The Clerk shall receive a fee of fifty cents for thus registering a midwife, which shall be paid by the person so registered. Such President and Secretary of the local Medical Society or Association shall be satisfied of the competency and good character of the midwife before granting and issuing the certificate as aforesaid.

Sec. 2. Any such registered midwife who may move from one county to another in this State, shall again register in the office of the Clerk of the Superior Court of the county into which he or she removes for the purpose of residing therein as provided in the preceding section.

Sec. 3. Be it further provided, That upon complaint of any licensed physician, against any registered midwife for incompetency, malpractice, or lack of proper knowledge of the duties of

midwifery, such midwife shall be cited to appear before the local Medical Society or Association from which he or she holds a certificate, having first been given five days' written notice of the charge or charges preferred and of the time and place of hearing. The hearing shall be had at such time and place, unless continued for cause, before said Society or Association, five members thereof constituting a quorum, and if a majority of the members trying the matter shall find the midwife guilty of incompetency, malpractice or lack of proper knowledge of the duties of midwifery, as aforesaid, then the certificate theretofore granted to such midwife shall be revoked and taken up and cancelled by said Society or Association and the President and Secretary of the Society or Association shall so certify to the Clerk of the Superior Court, who shall write the words "Certificate Revoked" across the registry of such midwife's name where previously recorded as aforesaid.

Sec. 4. Be it further enacted, That when any child is born attended by a midwife and said child has any affection of the eye or eyes at the time of birth, or such affection shall develop soon thereafter, then it shall be the duty of the attending midwife to report such fact to a regular practicing physician, giving the name of the child's parents and the place where said is to be found.

Sec. 5. For the purposes of this Act, a midwife is hereby defined to be a person, male or female, not a practicing physician, who assists women in child-birth, or practices the obstetric art.

Sec. 6. Be it further enacted, That any person other than a practicing physician, who shall practice midwifery without first being registered as provided by sections one (1) and two (2) of this Act, or who shall fail to make a report as provided by section four (4) of this Act, shall be deemed guilty of a misdemeanor and on conviction shall be punished as provided by section 1039 of Volume 3 of the Code of Georgia of 1895.

Sec. 7. Be it further enacted, That all laws and parts of laws in conflict with this Act, be and the same are hereby repealed.

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A sinus leading high up in the axilla and discharging a moderately clear fluid may communicate with the shoulder joint or pleura.

*American Journal of Surgery.*



# EDITORIALS

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We will present, postpaid, on request, to each contributor of an original article, twenty (20) marked copies of THE JOURNAL-RECORD OF MEDICINE containing such article.

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## EVOLUTION AND THE CHILDREN OF FREEDOM.

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The present writer recently had the pleasure of taking part in a debate upon "Freedom and the Republic," in which he ventured to assert that the nation's children, being its most precious possession, should receive at least a modicum of the national care. He thought the community should stand behind the parent, and the nation behind the community; and that where the parent failed in his duty to the child the community and the nation should be prepared to deal with both the parent and the child according to their deserts. What the deserts of the child may be was the point at which the present writer and the accomplished essayist of the meeting crossed words. It was argued that the child had no rights beyond those provided by the law of Evolution, which, with red ravening maw ruthlessly cuts down all who might be unfit to wage successfully an individual war against that nature which is "so careful of the type, so careless of the single life."

This appears to be but a sad commentary upon the kindly religions, the hospitals, the homes for the friendless, the orphanages, and the thousand charities which grace the land. Is

it well that the child, absolutely irresponsible for his position or even for his existence, should suffer cold and hunger, ignorance and disease, and grow up but the shadow of the man he might have been because evolution has led mankind through dark and devious paths sometime, and still perforce must tread therein? or was the gentleman laboring under a misunderstanding in relation to the Law of Evolution? It has doubtless been true that the battle is to the strong, and that the fittest have the greatest chance of survival, and always must be true. But there are various forms of strength. The wounded buffalo calf separated from the herd was the sure prey of the relentless wolf; the strength of the antelope lies in its power to run away; some richly hued insects escape because they resemble the stinging wasp. The buffalo teaches us the value of combination; the antelope of removing our kind from danger, and the mimetic insect that there are other ways of making strong the weakling besides the heathen method of exposure. The Law of Evolution has already taken on many forms, and it is growing now in its most beautiful and bountiful shape. It ceased some centuries ago to be of necessity a cruel law. Man long ago began to discover that he may one day better evolve through kindness than through capacity; through combination than through rivalry; thrift than through extravagance. It lies in great part with us doctors to guide this sentiment aright, and to see to it that the stream of less robust humanity, be neither in quantity nor quality a danger to the whole. This is to be accomplished by such a wise and far-seeing use of the art of preventive medicine in its widest sense that fewer weaklings shall be born, and these shall be so carefully tended and matured that our cities shall harbor no more of those thousands of degenerates who degrade race, are a source of constant menace and expense, and a standing rebuke to our civilization.

S.

## INHERITED SYPHILIS.

The question of syphilis being inherited alone from the father, the mother remaining uninfected, has always been an interesting, though obscure one, and many elaborate arguments have been advanced to prove and disprove this theory. A new field of investigation has been opened by the discovery of the *sperochaeta pallida*, and its almost universal acceptance as the cause of syphilis, or at least an etiological factor. Lucas\* has recently asserted that purely fraternal syphilis being transmitted to offspring is a view no longer tenable. He claims that it seems impossible that a motile organism exceeding in length the diameter of an ovum, could possibly penetrate and multiply in it without destroying it. Therefore, he lays it down as an axiom that inheritance is invariably through the syphilized mother, which conclusion is supported by Colles' law. When virulent, the *spirochetes* penetrate the chorion or placenta and occasion miscarriages, macerated fetuses or premature births; when the virus is attenuated (rather when the host's resistance is greater) the placenta protects the developing fetus, and infection takes place only through the umbilical vein on the separation of the placenta, thus explaining the appearance of the secondary symptoms in the infant from two to three months after birth. In these cases the separation of the placenta is the first stage, and corresponds to the chancre of acquired syphilis.

Kassowitz, in an able paper in 1876, opened the study of this subject, and his arguments in favor of paternal heredity have not been carefully answered from the opposite view until a recent publication by Matzenauer, who, with Lucas and Sturgis, insist that every syphilitic child has a syphilitic mother.

In this connection I have consulted Keyes Monograph on Syphilis to obtain his views of the subject. He says there are five ways in which a fetus or child may become infected with syphilis: 1. at the moment of conception, by the father's semen; 2. at the moment of conception by the mother's ovum; 3, by means of the placental circulation to the healthy fetus; 4, infection during parturition; 5, after birth by a kiss, or in suckling.

Although admitting that almost universally syphilographers believe in infection through the semen—the mother escaping in-

fection—pathologists have always maintained a reasonable doubt concerning this unique seminal transmission, which is not even alleged for any disease except syphilis. Keyes\* arrays the evidence upon each side. In favor of paternal heredity is alleged the obvious fact that the father and child are certainly syphilitic, and the mother apparently sound.

Against it is urged that the mother is not absolutely sound; and this is exhibited in various ways. In the first place, she is subject to Colles' law—the child being able to infect any non-syphilitic person except its own mother. This immunity to syphilis exhibited by the mother of a syphilitic child means that she is in some sense syphilitic. But in what sense? Either she has absorbed from the fetus or developed some immunizing substance, or, on the other hand she is actually syphilitic. In favor of the former theory are: First, certain reported exceptions to Colles' law, the mother developing chancre of the nipple and a general syphilis after nursing her infant. (Matzenauer rejects all these exceptions as being unreliable.)

Second, the repeated insistence of innumerable observers that in such instances further syphilitic pregnancies may be prevented by *anti-syphilitic treatment of the father alone*.

Against it are:

1. Our inability to evoke a similar experimental immunity in man or monkey.
2. The fact that some ninety per cent. of syphilitic women do not have, or do not remember having, any early symptoms of the disease.
3. The frequency of the appearance in later years of tertiary lesions upon these apparently clean mothers. In such instance we may fairly say that the mother was syphilitic, but skipped her early symptoms.
4. The decreasing intensity of the infection in successive pregnancies; the one thing most likely to affect the vitality of the fetus and its susceptibility to disease is the condition of the placenta, and Matzenauer has attempted to show that the decreasing virulence of children goes hand in hand with decreasing syphilitic inflammation of the placenta.

Briefly stated, the above are a few of the facts as elucidated by men who have given the subject much thought and study. That paternal heredity ever occurs, Keyes says he does not

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\*Lancet London, Feb. 1st '08

know, but claims that the frequency of the appearance of tertiary lesions in apparently healthy mothers surely proves that it is less common than is generally believed.

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### CANCER RESEARCH.

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The Seventh Annual Report of the Work of the Cancer Laboratory of the New York State Department of Health, at Buffalo, shows considerable matter of interest from an experimental standpoint, and it is to be hoped that eventually discoveries of much practical value will emanate from the correlation of the facts observed or confirmed by these enthusiastic scientists.

Especial attention is again called to the evidence bearing on the contagiousness of cancer, which undoubtedly occurs in mice when placed in infected cages, and from the increase in the number of publications bearing upon the so-called "cancer-houses," in which an universal number of individuals contract the disease, they believe this possible method of its spread should not be entirely neglected. Dr. Gaylord therefore urges the Department of Health to recommend to all health officers the desirability of proper sterilization and disposal of all dressings of cancer cases, and the fumigation and sterilization of rooms occupied by cancer patients.

Of the spontaneous cure of cancer, Gaylord and Clowes say that however deep the skepticism may be regarding spontaneous cure of human carcinoma—and this skepticism is certainly widespread,—there is absolutely no doubt of the occurrence of spontaneous cure in mice with cancer, no less than 101 clearly defined cases having come under their observation during the year just passed. The question of spontaneous cure of cancer in human beings is of still greater interest and importance, and although but few authentic cases are to be found in the literature, they acquire an added significance when considered in conjunction with the results on animals.

The conclusions of these authors are that: Spontaneous cure of mice successfully inoculated with Jensen tumor occurs in twenty-three per cent. of the animals.

The chances of such spontaneous cure are inversely proportional to the size of the tumor. The frequency of the occurrence and its distribution in animals suggests that it may be more frequent in human beings than is generally supposed.

The occurrence of spontaneous recoveries from cancer, indicating the existence of immune forces capable of terminating the disease, demonstrates that cancer is not necessarily incurable, and should serve as an additional stimulus to research directed toward the development of a serum therapeutic treatment.

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### UROTROPIN EXCRETED IN THE BILE AND PANCREATIC JUICE.

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It is with particular interest that we note the original and experimental work by Mr. Crowe, student, Johns Hopkins Medical School, along the line indicated by the above title. Mr. Crowe is an Atlanta man, and is a son of Dr. W. A. Crowe, who is a well-known and highly esteemed physician of this city.

According to the March issue of the John's Hopkins Hospital Bulletin, Mr. Crowe reported, at a recent meeting of the Hopkins Medical Society, the result of a series of experiments made to determine the fate of urotropin in the body and its efficacy as a sterilizing agent in the bile and other secretions of the body.

It was determined by experiments on dogs that after the administration of urotropin by mouth, it was excreted both in the bile and pancreatic juice.

In view of these findings, observations were made on a series of patients in the hospital who had biliary fistulæ. Bacteriological studies were made before and after giving the drug; and in every case the infecting organisms rapidly disappeared when the dose of urotropin given was 75 grains or more a day. As in the urinary bladder the organisms appear again as the dose is decreased.

The bile discharged through the fistula, when acidified and distilled, always gives the test for formaldehyde, the amount present varying with the amount of urotropin given.

In every case the patient's general condition improved, the discharged bile changed from a dirty, turbid fluid, to the golden-yellow of normal bile, and the fistulæ closed rapidly.

Urotropin was shown to be present repeatedly in the cerebrospinal fluid, even after very small doses by mouth. In one case with a badly infected cerebrospinal fistula, with sloughing and a purulent discharge, the organisms gradually disappeared after urotropin was begun, the fistula closed, and the patient made a good recovery.

Formaldehyde was shown to be present also in the pus obtained from a gonorrhœal knee-joint, but sufficient time has not as yet elapsed to report on its therapeutic effect in this case.

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## NEWS AND NOTES

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The Chicago Policlinic announces a special practical course in surgery, gynecology, skin, venereal and rectal diseases and diseases of the stomach, beginning April 6, 1908, and continuing three weeks.

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A concert is given at the Berlin Charite every Saturday between 5 and 6 p. m. for the benefit of the patients, a woman's club providing skilled musicians for the purpose.

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The famous collection of more 2,000 dermatologic casts, owned by the late Professor Lassar, has been presented by his widow to the City of Hamburg, his native town.

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The dedication exercises of the New Tabernacle Infirmary were held March 11, about 2,000 people being present. This building is a three-story, commodious one, which will be equipped with all modern hospital appointments, and with the increased staff, will afford distinct improvement in the hospital facilities of Atlanta.



Messrs. Lea Bros. & Co., announce the dissolution of their firm on Dec. 31st, and the continuance of the business by their successors under the title of Lea & Febiger.

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The Alaska-Yukon-Pacific Exposition will be held at Seattle, Wash., opening June 1, and closing October 15, 1909.

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Lieutenant Colonel Blair D. Taylor, recently of the General Hospital at Hot Springs, Ark., has been ordered to Atlanta to succeed Colonel Gray, as Chief Surgeon of the Department of the Gulf.

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The tuberculosis exhibit of the Indiana State Board of Health has been loaned to the Richmond Health Department, and has been on exhibition in the city hall, where it has attracted much attention and favorable comment.

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At the annual meeting of the Medical Board of Macon Hospital Association, January 29, Drs. Max Jackson, William J. Little, James H. Shorter, Henry P. Derry, Jesse E. Wright, Maury M. Stapler, Charles C. Herrold, John A. Selden, Samuel B. Palmer, H. H. Johnston, Johnson M. Moore, Herbert Respass and Fred L. Webb were added to the staff of the hospital.

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#### NOTICE OF EXAMINATION FOR JUNIOR INTERN TABERNACLE INFIRMARY.

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Examination will be held in room 726, Candler Building, Tuesday, 8 p. m., April 21, 1908.

Term of service, eighteen (18) months, commencing May 1st.

The new Infirmary Building will soon be completed, which will give Interns excellent opportunities for practical experience.

For further information, address,

INTERN COMMITTEE,  
725-6 Candler Bldg., Atlanta, Ga.

The Banks County Medical Society met March 17. Officers elected: Dr. Vinscent D. Lockhart, of Maysville, President; Dr. J. D. Rice, of Homer, Secretary and Treasurer; Dr. T. G. Underwood, of Maysville, Delegate to State Association; Dr. O. N. Harden was elected as a member. A meeting was called for May 15th.

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#### FULTON COUNTY MEDICAL SOCIETY, MARCH 5, 1908.

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##### TROPICAL ULCER.

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Dr. Wilmerding exhibited a case of tropical ulcer, the history of which we will report in full in our next issue.

Dr. Andrews stated that the condition is rare, and due to a virulent and contagious organism. The course is always chronic.

Dr. Wilmerding added that it appears only in the skin, the mucus membrane being free.

Dr. Hoke exhibited a case of severely crushed ankle, upon which he had operated. The injury had been so great as to cause amputation of the thigh on one side. On the other the ankle had been broken and twisted out of all normal shape, and the heel destroyed. Plastic bone operations were indicated by the skiagraphs, and these were performed, giving a serviceable foot in proper position with ankle motion in all directions. The case shows the practicability of plastic operations upon bones, even in so complicated an inter-relation as those of the ankle joint.

The following delegates to the State Association, which will meet April 15, 16, 17, in Fitzgerald, are: Drs. J. C. Olmstead, A. W. Stirling and Michael Hoke.

##### THE PROGRAM FOR APRIL.

April 2. (1) "The Opsonic Contents of the Body Fluids."  
J. E. Paullin.

Discussion: Claude Smith, H. F. Harris.

(2) "A Demonstration of the Anatomy of the Peritoneum and the Gastro-Intestinal Tract." W. B. Armstrong.

Discussion: T. V. Hubbard, F. W. McRae, W. P. Nicholson, F. Hodgson.

April 9. (1) "A Report on One Hundred and Twenty-Two Operations on the Knee Joint." M. Hoke, C. R. Andrews.

Discussion: W. S. Goldsmith, J. L. Campbell, S. T. Barnett, F. K. Boland.

(2) "Chronic Affections of the Heart Muscle." G. P. Huguley.

Discussion: W. F. Wilmerding, R. T. Dorsey, J. H. Hines.

(3) "Nervous Diseases Caused by Alcohol and Metallic Poisons." J. Cheston King.

Discussion: J. S. Todd, M. Mc H. Hull, J. C. Olmstead, W. E. Taylor.

Lectures for the People: Drs. M. Hoke, Chairman; Ellis, H. F. Harris, Kime, Paullin, C. A. Smith, Wolff.

Minimum Fee Scale: Drs. E. C. Davis, Chairman; W. B. Armstrong, Barnett, Hoke, Hodgson, Hull, McRae, Nicholson, Roy, Taylor, Westmoreland.

Concerning a Collector: Drs. Ballenger, Chairman; Strickler, Huguley, Stephens, Hutchins.

Committee on Membership: Drs. LeConte, Chairman; Wilmerding, White.

The following committees have been appointed by Dr. A. W. Stirling for the year 1908:

Board of Censors: Drs. E. C. Davis (1 yr. Ch.), J. C. Olmstead (2 yrs.), W. B. Emery (3 yrs.).

Publication Committee: E. G. Ballenger, Chairman; E. Bates Block; W. S. Goldsmith.

Public Health and Legislation: Drs. C. W. Strickler, Chairman; C. A. Smith, L. B. Clarke.

Case Committee: Drs. W. B. Armstrong, Chairman; E. G. Ballenger, R. L. Dorsey, J. H. Hines, C. D. Roy, J. L. Campbell, W. S. Goldsmith, R. B. Ridley, Jr., A. Smith.

Programme Committee: Drs. A. W. Stirling, Chairman; J. W. Duncan, J. Ross Simpson.

The Medical Board of Grady Hospital has decided that in the future the medical and surgical services of the hospital should be divided and separate.

Before this time the services have been combined, the same

house physicians serving in both medical and surgical capacities.

There have been five house physicians elected by competitive examination from young medical graduates, the term of service of each being two years. According to the new plan this number will be increased to eight, of which three will be chosen for exclusive medical service and five solely for surgical work of the institution. The ambulance men will be surgeons. •

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Dr. J. M. Sadler, a prominent Physician of Montgomery, Ala., died March 7, while attending the Montgomery Medical Society. He had just entered the hall, where he spoke to his friends and sat down. In a few moments he died of hemorrhage of the brain. Dr. Sadler was 50 years of age, and was a native of South Carolina.

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Dr. Dunbar Roy has examined 900 employees of the Southern Railway, testing their vision for color blindness, and their hearing abilities. This work has been done under the direction of Dr. Applegate, chief surgeon of the railway, for the purpose of lessening wrecks, many of which are attributed to failure of employees to see signals aright. Dr. Roy has found very few who fail to come up to the standard required by the road.

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#### INTERNATIONAL CONGRESS OF TUBERCULOSIS.

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The following prizes are offered by the International Congress of Tuberculosis, which meets in Washington, D. C., next September:

A prize of \$1,000 is offered for the best evidence of effective work in the prevention or relief of tuberculosis by any voluntary association since the last international congress in 1905. In addition to the prize of \$1,000, two gold medals and three silver medals will be accompanied by diplomas or certificates of award.

2. A prize of \$1,000 is offered for the best exhibit of an existing sanatorium for the treatment of curable cases of tuber-

culosis among the working classes. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded.

3. A prize of \$1,000 is offered for the best exhibit of a furnished house for a family or group of families of the working class, designed in the interest of the crusade against tuberculosis. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded.

4. A prize of \$1,000 is offered for the best exhibit of a dispensary or kindred institution for the treatment of the tuberculous poor. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded.

5. A prize of \$1,000 is offered for the best exhibit of a hospital for the treatment of advanced pulmonary tuberculosis. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded.

6. The Hodgkins fund prize of \$1,500 is offered by the Smithsonian Institution for the best treatise that may be submitted on "The Relation of Atmospheric Air to Tuberculosis."

7. Prizes for educational leaflets:

A prize of \$1,000 is offered for the best educational leaflet submitted in each of the seven classes defined below. In addition to the prize of \$1,000, a gold medal and two silver medals will be awarded in each class.

Competitors must be entered under assumed names.

- A. For adults generally (not to exceed 1,000 words).
- B. For teachers (not to exceed 2,000 words).
- C. For mothers (not to exceed 1,000 words).
- D. For indoor workers (not to exceed 1,000 words).
- E. For dairy farmers (not to exceed 1,000 words).
- F. For school children in grammar school grades (not to exceed 500 words).
- G. Pictorial booklet for school children in primary grades and for the nursery.

8. A gold medal and two silver medals are offered for the best exhibits sent in by any States of the United States, illustrating effective organization for the restriction of tuberculosis.

9. A gold medal and two silver medals are offered for the best exhibits sent by any state or country (the United States excluded), illustrating effective organization for the restriction of tuberculosis.

10. A gold medal and two silver medals are offered for each of the following exhibits:

A. For the best contribution to the pathological exhibit.

B. For the best exhibit of laws and ordinances in force June 1, 1908, for the prevention of tuberculosis by any state of the United States. Brief required.

C. For the best exhibit of laws and ordinances in force June 1, 1908, for the prevention of tuberculosis by any state or country (the United States excluded). Brief required.

D. For the best exhibit of laws and ordinances in force June 1, 1908, for the prevention of tuberculosis by any municipality in the world. Brief required.

E. For the society engaged in the crusade against tuberculosis having the largest membership in relation to population. Brief required.

F. For the plans which have been proven best for raising money for the crusade against tuberculosis. Brief required.

G. For the best exhibit of a passenger railway car in the interest of the crusade against tuberculosis. Brief required.

H. For the best plans for employment for arrested cases of tuberculosis. Brief required.

11. Prizes of two gold medals and three silver medals will be awarded for the best exhibit of a workshop or factory in the interest of the crusade against tuberculosis.

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PRELIMINARY PROGRAM OF THE ELEVENTH ANNUAL MEETING OF THE AMERICAN GASTRO-ENTEROLOGICAL ASSOCIATION TO BE HELD AT CHICAGO, ILL., JUNE 1 AND 2, 1908.

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1. President's address. J. P. Sawyer, Cleveland.
2. A new method of ascertaining the permeability of the pylorus. Max Einhorn, New York.
3. Ischochymia. F. H. Murdoch, Pittsburgh.
4. An explanation of the motor activities of the alimentary canal in terms of the myenteric Reflex. Walter B. Cannon, Boston.

5. (a) Further observations on the chemic co-ordination existing between the salivary glands and the secretion of the stomach.

(b.) Effect of splenectomy on the gastric secretion. J. C. Hemmeter, Baltimore.

6. Cholecystitis. H. W. Bettmann, Cincinnati.

7. Notes of progress in gastroenterology. A. L. Benedict, Buffalo.

8. The nervous influence on the production of sugar in the body. J. J. R. MacLeod, Cleveland.

9. The behavior of some indigestible carbohydrates in the alimentary tract. Lafayette B. Mendel, New Haven.

10. A comparison of the guic and benzidin tests for invisible hemorrhage in diseases of the digestive organs. Franklin W. White, Boston.

11. Paper. J. Kaufmann, New York.

12. Intestinal sand—one of its sources. Jesse S. Myer, Jerome E. Cook, St. Louis.

13. Some recent experiences with gastric ulcer. Wm. Gerry Morgan, Washington.

14. Pathology of malignant growths. W. T. Howard, Cleveland.

15. Gastromyxorrhoea. J. Friedenwald, Baltimore.

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The Seventeenth Annual Meeting of the Association of Military Surgeons of the United States will be held in Atlanta October 6-9, 1908. The officers of this Association, which will be heartily welcomed to Atlanta, are: Asst. Surg., Gen. George Tully Vaughan, P. H. and M. H. S., Washington, D. C., President; Rear Ad. Presley M. Rixey, U. S. N., Washington, D. C., First Vice-President; Col. Jas. H. Weaver, N. G. Pa., Norristown, Pa., Second Vice-President; Col. Wm. C. Gorgas, U. S. M., Ancon, Canal Zone, Panama, Third Vice-President; Major James E. Pilcher, U. S. V., Carlisle, Pa., Secretary; Major Herbert A. Arnold, N. G. Pa., Ardmore, Pa., Treasurer; Capt. J. C. DeVries, N. G., N. Y., Wakins Glen, N. Y., Asst. Secretary.



Richard Douglas, M. D., one of the South's leading surgeons, died of Bright's disease February 19th, at his home, in Nashville, Tenn. He was professor of gynecology and secretary of the faculty of the Medical Department of Vanderbilt University. Dr. Douglas was a man of much force and determination, an able teacher, a skillful surgeon with an enviable reputation and many enthusiastic admirers. 8 1911

HIS EYES OPENED.

"Why is she getting a divorce?"

"On the grounds of misrepresentation. She says that before they were married he claimed to be well off!"

"And what does he say?"

"He says he was, but didn't know it."

## BOOK REVIEW

**COSMETIC SURGERY.**—The correction of featural imperfections. By Charles C. Miller, M. D.

Including the description of a variety of operations for improving the appearance of the face. 136 pages. 73 illustrations. Prepaid, \$1.50. Published by the Author, 70 State St., Chicago, Ill.

This little book, perhaps, was not intended to cover the subject fully. In some points we find considerable detail, in others a marked superficiality. One can get a clue to many operations for the correction of real, or imagined, deformities, but scarcely enough information to warrant attempting the operations without further study and much experience. There is no reference to troublesome hemorrhage as might occur in operations about the mouth or in the nose. The subject of the electrolytic removal of hairs is carelessly treated. Parafin work is a bit more cautiously described. Some of the operations that vanity might image could well afford a field for much trouble and possibly damage suits. The description and treatment of some disease conditions are much too laxly given.

The illustrations average not very good. The price of the book seems excessive. However, the author gives some good points, and one could get a start for experimental work from its pages. Perhaps he may later produce a more perfect and complete work.

## SELECTIONS AND ABSTRACTS.

### REPORT OF THE BOARD OF HEALTH.

To the Honorable Board of Health:

Gentlemen: I have the honor to submit the following report of the work done in the laboratory of hygiene during the year 1907.

#### DIPHTHERIA EXAMINATIONS.

During the year 771 cultures were examined for diphtheria, as follows:

|                              | Primary. | Secondary. |
|------------------------------|----------|------------|
| Positive diphtheria cultures | 94       | 113        |
| Negative diphtheria cultures | 193      | 89         |
| Doubtful diphtheria cultures | 60       | ...        |
| Total cultures .....         |          | 549        |

#### SPUTUM.

|                              | Positive. | Negative. |
|------------------------------|-----------|-----------|
| Sputum examination for T.B.  | 38        | 36        |
| Total examinations for T. B. |           | 74        |

#### MILK EXAMINED.

|  |       |
|--|-------|
| Number samples analyzed (obtained by inspector)..... | 2,132 |
| Number samples (sent in).....                        | 29    |

Total number analyzed ..... 2,161

#### DIPHTHERIA.

The report shows that there has been a marked decrease in the number of cases of diphtheria during 1907 over previous years. This decrease appears to be due, to a certain extent, to the fact that physicians now send in cultures from every case of suspicious sore throat. This is evidenced by the 193 cultures which were sent from suspicious cases, but which proved negative. Altogether, this indicates that we have almost complete control of all cases of diphtheria which may develop in this city.

#### TUBERCULOSIS.

By reason of the increased appropriation last July, we were able to take up the free examination of sputum for the physicians

throughout the city. Previously we had no registration or control of tuberculosis. These examinations were taken up so as to insure accurate statistics for the disease, and with a view to possible future education of the unfortunate individuals as to control the spread of the disease. From July 1 until December 31, 74 specimens of sputum were examined in the laboratory, 38 of these being positive and 36 negative.

#### MILK.

During January 1907, we submitted to the board of health, the milk ordinance which had been drafted with a view to improving the health of the city through its milk supply. This ordinance, after being adopted by your board, was submitted to the council, and after considerable opposition, was finally adopted. This ordinance was somewhat radical and some of the requirements were entirely new to the dairymen. Our investigations show that much of our trouble was due to ignorance and carelessness. In enforcing the ordinance, we have endeavored not to work a hardship, but have proceeded along the lines of education. The Inspectors have cooperated in the enforcement of the new ordinance, and the improvement in the milk supply is surprising, and we anticipated even greater improvements during the present year.

We are glad to report that the Pasteurizing plant, whose milk was found to be dangerous, was forced to discontinue operations, and now only fresh milk is sold in the city.

We have actively enforced that part of the ordinance which applies to the selling of cream, and all cream sold in the city comes up to the required 20 percent. butter fats. This has forced out of business the unscrupulous people who have been selling adulterated cream. In this connection we would call attention to the requirements for ice cream to contain 14 percent. butter fats. We suggest that this be changed to read 10 percent. butter fats for fruit ice cream, and 12 percent. butter fats for plain ice cream.

#### MOSQUITOES.

During the summer of 1907 the mosquito ordinance was actively enforced by Dr. Kennedy, and excellent results followed the employment of inspectors to prevent the development of mosquitoes about the residences. The members of the board will recall that this mosquito work was originally undertaken princi-

pally for the purpose of exterminating the yellow fever mosquito (*stegomyia*), and this was practically accomplished by the work of the inspectors. However, there was a small number of *culex* mosquitoes which developed along the sewer trunks. This was due to the water famine which prevented the flushing of the sewers, and, therefore, allowed the mosquitoes to develop in the stagnant pools.

### WATER SUPPLY.

During the year we made a number of examinations of the city water and found the condition the same as previous years, with the exception of the period of the water famine, during which time the number of bacteria were increased from 1,500 to 2,000 per cubic centimeter. After this time the water again returned to the normal average of 15 to 20 bacteria per centimeter.

As we have mentioned to the board in the past, the water appears to be as good as can be obtained from our present source of supply. However, there is more or less pollution of the water above the point from which the supply is obtained, and, as the population along the river bank increases, this pollution is hardly dangerous at this time, but in the course of time it is liable to present a serious situation. It is urgent, therefore, that steps should be taken towards securing control of the water shed for the city supply. If appropriation can be secured for this purpose it would pay the city to begin this investigation as early as possible.

Respectfully submitted.

CLAUDE A. SMITH, M. D.,

Director of Laboratory of Hygiene.

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### SOUTH CAROLINA TO IMPROVE HER MEDICAL PRACTICE LAW.

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At the meeting of the Legislative Committee of the State Medical Association in conjunction with members of the Association from nearly every county in the State, a bill was drawn

up looking toward the improvement of the law now existing as to medical practice in this State.

#### THE BILL.

To amend an act entitled "An act to regulate the practice of medicine in South Carolina, to provide for a State Board of Medical Examiners and to define their duties and powers," approved February 27, 1904.

Section 1. Be it enacted by the General Assembly of the State of South Carolina that an act entitled "An act to regulate the practice of medicine in South Carolina, to provide for a State Board of Medical Examiners and to define their duties and powers," approved February 27, 1904, be, and the same is hereby amended by inserting immediately after Section 5 thereof a section to be known as Section 5a, as follows:

"Section 5a. The said Board of Medical Examiners is hereby authorized and empowered to suspend or revoke subject, on appeal, to revision by the circuit courts of the State, by a majority vote of its total membership, the license of any practicing physician or surgeon qualified under any provision of this act, and whether qualified prior or subsequent to the passage of this act, after due notice and fair opportunity for hearing, upon its being made satisfactorily to appear that the holder thereof is guilty of felony or gross immorality or is addicted to the liquor or drug habit to such a degree as to render him or her unworthy or unfit to practice medicine in this State, or has been convicted in a court of competent jurisdiction of illegal practices. And the said board is further authorized and empowered to administer oaths in the taking of testimony upon any and all matters pertaining to the business or duties of the Board."

Section 2. That said act be, and the same is hereby, further amended by striking out Section 13 of said act and inserting in lieu thereof the following:

"Section 13. It shall be unlawful for any person or persons to practice medicine or surgery or any branch or specialty of the same in this State, who has failed to comply with the provisions of this act, and anyone violating the provisions of this act shall be deemed guilty of a misdemeanor, and for each offense, upon conviction of any court of competent jurisdiction,

shall be fined in any sum not less than fifty dollars, nor more than three hundred dollars, or imprisonment in the county jail for a period of not less than thirty, nor more than ninety days, or both, at the discretion of the court; one-half of the said fine to go to the informant, and the other half to the State; Provided, That dentists and mid-wives shall not be subject to the provisions of this section; Provided, further, That the State Board of Medical Examiners shall issue license to osteopaths and homeopaths specifically for the purpose of practicing respectively when the applicant presents a diploma from a duly authorized school of osteopathy or homeopathy and satisfactorily passes examination before the State Board of Medical Examiners on all regular branches upon which applicants for license to practice medicine are examined except materia medica and therapeutics, major surgery and the practice of medicine.

Section 3. All acts and parts of acts inconsistent with this act are hereby repealed.

Section 4. This act shall go into effect immediately upon its approval by the governor.—*Medical Journal of South Carolina, Feb. '08.*

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## TRUTH AND THE AMOUNT OF YOUR PRACTICE.

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### WHY DOES THE DOCTOR EXAGGERATE HIS STORY OF SUCCESS.

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Oliver Wendell Holmes, the gentlest of philosophers of the medical guild, contended that horses had "all the forms of moral excellence, except truth, which does not agree with any kind of horseflesh." We, who are neither gentle nor philosophers, give it as our opinion that the young doctors may, in some particulars, be classed with Holmes' horses. They may present all forms of moral excellence, except truth as to the extent and size of their practices, which does not seem to agree with any kind of young-doctor-flesh. The young doctor, as we have found him and as we have personally experienced him, is, if normal and healthy, an exceedingly cheerful liar in regard to his professional

success. In setting down this fact, we wish that there could be some other word to use, for "liar" has a harsh and pernicious sound, while the lies of the young doctor are in every way harmless, in that they seldom or never deceive anyone. They are told with the same thoughtlessness which characterizes many of our verbal conventionalities—such as the "my dear sir," with which we address a letter to our enemy, or the "with sentiments of respect," with which we close a communication to one who has not our respect or that of any other person under heaven.

The young doctor who has had the benefit of pure and orthodox training, sometimes couches his lies with vague and indefinite terms and therewith soothes his delicate conscience. If asked how much he has made in practice within a fortnight, he replies that he has booked so much, his system of booking being peculiarly his own.

A hard-headed business man, who went on an excursion with a number of young doctors and who was made the victim of their numerous professions of prosperity, declared to me that medical men must save more money than those of any other vocation, inasmuch as all of those who had talked to him were making a great deal, while none of them spent much money and all owed as much as they could without bringing about a condition of commercial unrest.

I have gotten so that I am greatly refreshed to find a young physician who is not, by his own confession, grievously overworked. As a rule, if I ask a young doctor how he feels, he yawns a forced yawn and tells me that he will be feeling all right if he can get in a night's sleep without being disturbed by his many over-exacting patients. Yet, as he walks away I am always inclined to believe that I detect a peculiar shininess of the seat of his trousers and a baginess about the knees which my peculiar diagnostic skill and long experience, impress me as being due to no other etiologic factor than sitting for prolonged periods in a comfortable office chair.

And why, ye scientific investigators, is the young doctor so inveterate a liar on this one subject? Are we to account for it as we do for the whistle in which one always indulges when he passes a cemetery on a dark night—merely to keep up the spirits on a very desolate and lonely occasion? Or, on the other hand, does he indulge in lies merely for the reason that a dog has fleas—

# HY- DRO- LEINE

AN EMULSION  
OF COD-LIVER OIL  
OF PROVED  
RELIABILITY

A Sample of  
Hydroleine  
with literature  
will be sent gra-  
tis, on request.

Pure, fresh cod-liver oil—  
thoroughly emulsified, unusually  
palatable, extremely digestible and  
devoid of medicinal admixtures.

Sold by druggists

THE CHARLES N. CRITTENTON CO.  
115 FULTON ST., NEW YORK

merely to show that he is a dog—simply to show that he is a young doctor.

A friend of mine remarked to me that young Doctor Blank was out six nights in the week in his large obstetrical practice—she knew it because he told her so. And this friend of mine added, “I did not know there was that much charity obstetrical practice in this community.” Which merely indicates, my dear young doctors, that your stories of exploit are received by the simple minded layman with an inward and indulgent smile and not with the same degree of seriousness with which you deliver them.

That the young doctor’s lies are not told with any intent to deceive, however, is indicated by the fact that they are told to older and other practitioners quite as freely as the uninitiated layman. A physician of the vintage of 1907 recently wrote me: “I should be very glad to submit a report of this case. The condition is an exceedingly rare one. I recall but four like it in my



entire experience!"—an experience which has extended from July, 1907, to January, 1908!

But why protest against the thing? With young doctors it is very much like the assumption of great dignity—a silly puerile, but very harmless thing which is all right if outgrown early. As we grow to be men, however, pomposity and prevarications of prosperity become exceedingly transparent evidences of little mentality. When we have become men we should have put away childish things.—*Chicago Clinic and Pure Water Journal*, March, 1908.

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### THE BEST HE KNEW.

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Gladstone, a Jamaican negro, was assistant to a district physician in the Canal Zone, and, being rather poor in his Latin, the bottles had been numbered for his benefit. One day a Spanish laborer came in for medicine, and the doctor told his worthy assistant to give him two pills out of number six. After he had gone the doctor asked:

"Gladstone, did you give the man a dose of number six?"

"Oh, no, sah, Doctor; number six war finished, so I just give him one pill out of numbah foah and one out of numbah two."—*March Lippincott's*.

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Billy, aged twelve, took part the other day in a debate on imperialism. His opponent, in rebuttal, made a point by quoting the definition of empire from the Century Dictionary. Billy, nothing daunted, with all the air of Patrick Henry himself, rose up and said:

"It's all right for my opponent to quote from the dictionary, but as for me, I rely on *the facts!*"

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His clothes were spotted with dirt and grease, but a bright bunch of flowers adorned the lapel of his coat.

"What do you think of this?" he asked, proudly tapping his bouquet. "Where do you think I got it?"

"Don't know," admitted his friend, "unless—Why, maybe it grew there."—*January Everybody's*

# Peacock's Bromides

## The BEST FORM of BROMIDES

Each fluid drachm contains fifteen grains of the neutral and pure bromides of Potassium, Sodium, Ammonium, Calcium and Lithium.

In Epilepsy and all cases demanding continued bromide treatment, its purity, uniformity and definite therapeutic action insures the maximum bromide results with the minimum danger of bromism or nausea.

**DOSE**—One to three teaspoonfuls according to the amount of Bromides desired. Put up in half pound bottles only. Free samples to the profession upon request.

Peacock Chemical Co., St. Louis, Mo.  
Pharmaceutical Chemists.

# CHIONIA

## The HEPATIC STIMULANT

Prepared from Chionanthus Virginica  
Expressly for Physicians' Prescriptions

Chionia is a gentle but certain stimulant to the hepatic functions and overcomes suppressed biliary secretions.

It is particularly indicated in the treatment of Biliousness, Jaundice, Constipation and all conditions caused by hepatic torpor.

**DOSE**—One to two teaspoonfuls three times a day. Put up in half pound bottles only.

Free samples to Physicians upon request

Peacock Chemical Co., St. Louis, Mo.  
Pharmaceutical Chemists.

# CACTINA

## PILLETS

## A CARDIAC TONIC STIMULANT

From Cereus Grandiflora (Mexicana)

Each Pilet containing One One-Hundredth of a grain of Cactina

Indicated in functional cardiac troubles, such as tachycardia, palpitation, feebleness; and to sustain the heart in chronic and febrile diseases. It is not cumulative in its action.

**DOSE**—One to three Pillets three or four times a day. Put up in bottles of 100 pillels.

Free samples to Physicians upon request

Sultan Drug Co., St. Louis, Mo.  
Pharmaceutical Chemists.

# SENG

## A DIGESTIVE SECERNENT

A preparation of Panax (Ginseng) which is being successfully employed to stimulate the secretory glands of the alimentary canal.

Indicated in Indigestion, Malnutrition, and all conditions arising from a lack of digestive fluids

**DOSE**—One or two teaspoonfuls three or more times a day

**PUT UP IN 10 OZ. BOTTLES ONLY**

Free samples to Physicians upon request

Sultan Drug Co., St. Louis, Mo.  
Pharmaceutical Chemists.

## MEDICAL ITEMS

*Arteriosclerosis*: Autointoxication from faulty metabolism, and imperfect elimination ranks with gout and lead as a cause of high blood pressure. This, in time, leads to arteriosclerosis, cardiac hypertrophy and dilatation, mitral and aortic insufficiencies, cerebral apoplexy and retinal hemorrhage. Lowering the blood pressure is at once a preventive and curative measure. This is best accomplished by renal eliminations, and we know of no better remedy of this class than Alkalithia.

"Tongaline is a convenient and reliable remedy for that large class of painful complaints, whose etiology is so obscure as to present a veritable Chinese puzzle."

"In the treatment of all these diseases and diseased conditions resulting from the existence of the so-called rheumatic or uric acid diathesis, the action of salicylic acid from natural oil of wintergreen approaches so nearly to that of a specific as to be excelled only by that of cinchona on malarial toxæmia."

"The administration of the synthetic salicylic acid in full doses is almost always productive of unpleasant and often dangerous effects, such as irritation of the stomach, ringing of the ears and even delirium; thus necessitating a diminution of the dose or a temporary suspension of treatment.

This is also the case with many extemporaneous prescriptions having salicylic acid as a base and combined with other indicated agents.

## THE WAY ITS DONE

"Mother, may I get in the swim?"

"Yes, my darling daughter.

Buy your gowns from a Frenchy store,  
And don't wear half you oughter."

*December Lippincott's*

# BROMIDIA.

TO EVERY DRACHM OF FLUID ARE  
ADDED 15 GRAINS EACH OF PURE  
CHLORAL HYDRATE AND PURIFIED  
BROM. POT.; AND  $\frac{1}{8}$  GRAIN EACH OF  
GEN. IMP. EX. CANNABIS IND. AND  
HYOSCIAM.—IS THE ONLY HYPNOTIC  
THAT HAS STOOD THE TEST FOR  
THIRTY YEARS IN EVERY COUNTRY IN  
THE WORLD.

**ECTHOL IODIA PAPINE**  
**BATTLE & CO.,** CHEMISTS **ST. LOUIS, Mo., U. S. A.**  
CORPORATION,

## **SANMETTO** FOR **GENITO-URINARY DISEASES.**

A Scientific Blending of True Santal and Saw Palmetto with Soothing Demulcents  
In a Pleasant Aromatic Vehicle

**A Vitalizing Tonic to the Reproductive System.**

**SPECIALLY VALUABLE IN**  
**PROSTATIC TROUBLES OF OLD MEN—IRRITABLE BLADDER—**  
**CYSTITIS—URETHRITIS—PRE-SENILITY.**

**DOSE:—One Teaspoonful Four Times a Day.**

**OD CHEM. CO., NEW YORK.**



### **NEURILLA FOR NERVE DISORDERS NEURILLA**

If Patient suffers from **THE BLUES** (Nerve Exhaustion),  
Nervous Insomnia, Nervous Headache, Irritability or  
General Nervousness, give four times a day one  
teaspoonful **NEURILLA** →

Prepared from *Scutellaria Lateriflora*,  
*Passiflora Incarnata* and Aromatics.

**DAD CHEMICAL COMPANY, NEW YORK AND PARIS.**



## **THE LaGRANGE, GA., SANATORIUM**

**A Modern, Up-to-Date Institution for the care of Medical and  
Surgical Cases. Complete X-Ray and Electrical Outfit.**

**Under the Management of DR. HENRY R. SLACK.**

**Assisted by a Competent Staff.**

**--:**

**Graduate Trained Nurses in Charge.**

**Terms Moderate.**

**LaGRANGE, GA**

**No Physician can afford to be indifferent regarding the accurate filling of his Prescriptions.**

## A NEW METHOD OF TESTING THE FUNCTIONS OF THE DIGESTIVE APPARATUS.

Einhorn (Therapeutic Gazette, January, 1908) submits a method for investigating the functions of the intestinal tract, the principle of which is the administration of test substances with the food and observation of the effects of the digestive fluids upon these substances.

Practically, this test is made as follows: Patients are given, in a gelatin capsule, a string of beads with the following substances attached thereto: catgut, fish-bone, meat, thymus, potato, mutton fat. After administering the capsule, every stool is examined with the stool-sieve until the bead-string has been recovered. If diarrhoea is present the sifting may not be necessary, as the bead-string can readily be seen (usually at the bottom of a glass vessel).

Under normal conditions the bead-string appears after one or two days. It is then rinsed in cold water and examined. If digestion is normal we find that catgut, meat, and potato (except the skin) disappear entirely, thymus and fat almost entirely, whereas the fish-bone usually disappears, but occasionally it may be present. The nuclei of the thymus always disappears. In pathological conditions deviations from the normal are observed, not only in regard to the time of recovery of the beads (disturbances of motility), but also in regard to the presence of the food substances (disturbances of the digestive function).

The author divides his cases of intestinal digestive disturbances into two groups:

1. Those of pure nervous intestinal dyspepsia.
2. Those of genuine intestinal dyspepsia.

In that great class of cases of intestinal dyspepsia, in which the starch digestion alone is disturbed, Taka-Diastase (Takamine) has proved of especial value.

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Chemist (to poor woman)—You must take this medicine three times a day after meals.

Patient—But, sir, I seldom get meals these 'ard times.

Chemist (passing to next customer)—Then take it before.—  
*Glasgow Times.*

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## Practical Dermatology

*A Condensed Manual of Diseases of the Skin, Designed for the Use of Students and Practitioners of Medicine. By Bernard M. Wolf, M. D.*

Clinical Professor of Diseases of the Skin in the Atlanta College of Physicians and Surgeons; Editor of the Atlanta Journal-Record of Medicine; Ex-President of the Atlanta (Fulton County) Society of Medicine; Ex-Secretary of the Georgia State Commission on Tuberculosis, etc.

The special features of interest in this volume are the directness of the teaching (lack of verbiage); the alphabetical arrangement of the subjects; the large number of original illustrations (a number from the private collection of the famous German dermatologist—Unna); the modernness of the treatment; and the general "atmosphere" of practicality that surrounds the whole book. The first impression it conveys is that of real assistance to the busy practitioner who has not time to go into the remote connections of any given disease, and particularly in the commonly observed affections of the skin. There is no waste of words, no quibbling and no exploitation of theories.

There are over one hundred illustrations, almost all being half-tone reproductions of photographs showing the true dermatologic condition. These have been made with the utmost care, using the finest screen and thus defining every shade possible. The author's purpose has been to portray some stage of each of the common and important dermatoses.

The Formulary, being entirely independent of the therapy of the text, consists of over one hundred of the best accepted prescriptions employed in the treatment of diseases of the skin. These formulas cover the composition of Baths, Lotions, Ointments and Pastes, Powders, Miscellaneous Local Applications and Mixtures.

There are three sections: first, a General Introduction; second, the Disease of the Skin in alphabetical order; third, a Formulary of a hundred numbers. There is also a General Index covering the entire volume.

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No Physician can afford to be indifferent regarding the accurate filling of his Prescriptions.

MONGOLIAN BLUE PATCHES.

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These occur on the skin in about 90 per cent. of Japanese children. They are dark blue in color, not raised above the surface, have an indefinite margin, and do not disappear on pressure. They are more marked in males than in females. Occasionally a child of European parents presents such patches, and the suggestion is that this means a previous crossing with some Mongolian strain.—*Dr. Ernest Jones.*

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BROMIDE INSURANCE.

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Among the chemists who have testified to the purity of the salts entering the composition of Peacock's Bromides, particularly as to its extraordinary freedom from chlorides and the absence of other usual impurities, are names of such eminent men as Edward H. Keiser, Ph. D., Professor of Chemistry Washington University; H. Helbling, F. C. S., and F. W. Passmore, Ph. D., of London, England; Charles E. Caspari, Ph. D., Professor Chemistry St. Louis College of Pharmacy, and Edward Gude-man, Ph. D., Chicago, Ill.

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Peacock's Bromides is a mixture of bromides of Potassium, Sodium, Ammonium, Calcium and Lithium, 15 grains combined in each fluid drachm and equivalent in dosage to 15 grains of potassium bromide.

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## GRIM WARNING TO GIRLS.

We recently read a horrible story of a young lady who thoughtlessly jerked her head back suddenly to keep from being kissed, and broke her neck. This should be a terrible warning to girls not to jerk back. In fact, it would be better to lean forward just a little.—*Caldwell, (Okla.) Advance.*

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and Southern Medical Record, Established 1870.

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No. 2

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## WEANING.\*

BY H. MCHATTON, M. D., MACON, GA.

Mr. President and Gentlemen:—

You will probably agree with me that this subject is of extreme importance in the daily work of the average practitioner, and at the same time, one that is most sadly neglected.

Its importance is greater to the little patient than anything that has ever occurred in his life.

In my opinion, more children die from the effects of improper weaning than from all contagious diseases combined. I might with safety say from all causes during the same period of time.

Taking into consideration the vast importance of this neg-

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\*Read before the Georgia Medical Association, Fitzgerald, April 15, 16, 17, 1908.



lected subject, how many of us are prepared, off hand, to give full and specific instructions to the mother of a child of six, nine or twelve months in regard to its weaning.

There are things that we know are facts, and about which there is no question, in regard to children's food.

1st. That up to a given time there is no food comparable to the milk from the mother's breast.

2nd. This failing, the next safest is a wet nurse.

3rd. If we are willing to accept the concensus of opinion of the specialist in pediatrics all over the world, the next safest food obtainable are the various modifications of fresh cow's milk.

4th. That the milk from the Jenny or milk direct from the udder of the goat, as I have seen it much used in the tropics, is good, but practically unobtainable in our work.

5th. That there is no prepared food in the market which can be given alone and continuously for any length of time with safety.

This was proven most conclusively some years ago when a wave of enthusiasm swept over this country in regard to the use of prepared foods, which was followed by a wave of infantile scurvy, such as the oldest practitioner at that time had never seen, and it is to be hoped will never see again.

All of us interested in children's diseases saw more or less cases, almost exclusively in our best families, where our instructions in regard to infant's feeding were most thoroughly carried out.

To this class of foods, I wish to add, only to condemn, ordinary, canned condensed milk. This food usually gives you a beautiful, fat, pink and white baby, ideal to look at from a non-professional standpoint, but very prone to rickets and with absolutely no resisting power when any illness supervenes.

I recently saw some German statistics, which stated that of ten children taken from the mother's breast at birth, one would be alive at the end of the year; that of ten who were nursed exclusively during the first year, nine would be alive.

In fact, each month that the infant can be nourished, even

partially, by the mother, adds materially to its chances of surviving.

In regard to the time of weaning or beginning supplementary feeding, each case is a law unto itself. There is no time when feeding should begin, but there are emphatically times when it should not. No child should begin to take artificial food in the hot season when gastro intestinal troubles are so prevalent and so fatal. This rule should be ignored only in the face of the most dire necessity. If it is possible to carry a child through this season on short rations of natural food, and no gain in weight, we should be satisfied.

No child should be suddenly weaned when there is any other recourse. This procedure is always dangerous, and in the summer season, often fatal.

My rules in regard to weaning and supplementary feeding are as follows:

When a baby is born, I give the mother a weekly weight chart, tell her to weigh the baby each week and never give it anything but breast milk and water without instructions.

This request will be carried out about one time in twenty, no matter how much you insist on its importance, but every little helps; and after the baby is made sick a few times, you will get more co-operation from the mother.

As long as the infant is making a normal weekly increase, it is getting enough nourishment. If it is less than one year old, and the mother is well, no insistence on the part of the family should induce you to feed it.

On the other hand, when two or three weeks pass without a gain, or with even a loss, nutrition is not what it should be, and we must find out the cause.

If the infant's digestion is good, we must investigate the condition of the mother, and if nothing can be done to increase the quantity or quality of her milk, the time has arrived for feeding.

This is begun by giving the infant one bottle a day of a modification of milk appropriate to its age.

After taking this for a week, if there are no signs of indigestion, we can give two bottles, following the same rule, and gradually increasing to three or as many as may be required in

the given case to produce the normal gain in weight, it being understood that each bottle takes the place of a nursing period.

By following this simple line, we seldom have any trouble. A slight indigestion can usually be controlled by decreasing the quantity or strength of the artificial food, and in unusual cases, a return to the breast milk exclusively until all signs of indigestion have disappeared. Then begin the entire process over again. By this method, we have the inestimable aid of the breast milk until the infant has become used to the artificial food. This plan should be followed with infants of any age up to one year, which is about the time when the average child should be weaned. Children who have been exclusively breast fed can not take as strong solutions of modified milk as those of the same age who have been bottle fed.

I usually begin with a modified milk formula representing one-half or one-third of age of the child. It is a great deal safer to begin too low than too high, and much more scientific to avoid an indigestion than to cure it.

It is perfectly reasonable that a stomach that has dealt with nothing but the most perfect and God-given food should temporarily rebel at any artificial food that mere man, no matter how scientific, can produce.

Last November I had in one office hour two infants, one twelve and one thirteen months old, both magnificent specimens, who had never had any medicine or any food but breast milk, ideal age, children and season.

I gave the two mothers explicit orders as to the preparation of the modified milk. They, as unfortunately is so often the case, ignored my directions completely and put the children on plain milk. Each had an explosion in less than a week; and notwithstanding the fact that in each case, I had an abundance of excellent breast milk, it took me at least a month to get the infants in proper shape again.

These two cases only go to prove that no matter what is the age or condition of the child, or season of the year, we must always be careful when we begin artificial food with an infant.

Mothers will often come to you and announce the fact that their milk did not agree with the infant, and that several weeks ago they weaned it, since which time, they have been unable to get any food that would agree with it.

As this catastrophe usually occurs about the time they have begun to feed the child on any old thing, from sweet potatoes to grated ham, it is much more rational to attribute the existing conditions to the new food than to a sudden alteration in the original food that had agreed perfectly with the infant all of its previous life.

This line of reasoning seems so simple that you are more than surprised when you find that you cannot convince the mother that it is true.

The first thing to do in these cases is to try to re-establish the flow of milk. If this is successful, we are lucky; if not, we are in for a serious and often a fatal condition.

Another cause of a large mortality is the prevalent superstition that the milk of the pregnant woman is, as they express it, "poison to the child."

This superstition is so general that it causes the death of an untold number of children each year. They, the mothers, never wait to seek advice when they think they are pregnant, which proves in most instances not to be the case, but immediately and totally wean the child. It is usually some days before the explosion occurs, then more time is lost before advice is sought, on account of the sister superstition that a teething child should have loose bowels. The mother's milk is usually lost, and we are in for a serious and often a fatal condition.

How this prevalent superstition so at variance with all the laws of nature and presumably of Gad ever originated, or became so prevalent in a Christian country, is an enigma to me; but it is so thoroughly disseminated, that few of us who have much to do with sick children go a year without seeing death caused by it.

In the interest of the infant, I never advise weaning simply because pregnancy has occurred; but in the interest of the mother and unborn babe, it is often required,—the majority of our women not being physically capable of standing the double drain of pregnancy and lactation—sudden, complete weaning, never; invariably observe the usual gradual method.

In some countries, it is the common custom to continue nursing during the entire pregnancy, and I have had a case where

the mother nursed the child not only during the entire pregnancy, but after the birth of the second child, and no harm ensued to either of the three.

In one rather large and healthy family in my practice, in every pregnancy but the last, the mother was nursing the previous child when quickening occurred.

One of the great troubles in securing a proper compliance with our orders in regard to feeding is that they are often too complicated, and require an amount of education and special training to carry out that is not possessed by those in charge of the infant.

It may be more learned and more scientific for us to give directions about the varying fat percentages of the different layers of the top milk, throw in a few sentences about proteids, fats, carbo hydrates, æsine, etc., but what information does this convey to the anxious mother? She wants to know definitely what to give the infant and how to prepare it. If she cannot get this information from us in a manner that is clear to her, she will seek it elsewhere, and obtain it usually from those banes of our existence, the grandmother and the old, experienced negro nurse, who know more than any doctor about babies, at least in the opinion of the average mother.

To obviate this condition, I have been in the habit of using the following formulas for more than a quarter of a century with complete satisfaction. They may not be perfect, according to the latest laboratory investigations, but they are as near perfect as anything we can get carried out in private work; and what is more, so simple that anyone of ordinary intelligence can comply with the directions. I have used them continuously for over twenty-five years in both hospital and private work, and must say that practically every time I have sought new gods and gone out of this line, with the appropriate modifications to meet special indications in individual cases, it has been to my sorrow.

If any criticism can be made, it is that they are nearer the maximum than the minimum of the amount that the average infant should have.

As given below, they are intended for infants wholly bottle fed, and should be reduced as stated above in this paper.

To all the following tables lime water or soda solution should be added in the proportion of a tablespoonful to a pint. If soda solution is used, add before sterilization; if lime water, after sterilization.

All milk mixtures *must* be sterilized.

Diet during the first week:

|                   |               |               |
|-------------------|---------------|---------------|
| Cream .....       | 2             | teaspoonfuls. |
| Milk .....        | 3             | teaspoonfuls. |
| Water (hot) ..... | 3             | teaspoonfuls. |
| Milk Sugar .....  | $\frac{1}{4}$ | teaspoonful.  |

For each portion: to be given every two hours from 5 A. M. to 11 P. M., and in some cases, once or twice at night.

Diet from the second to the sixth week:

|                  |               |                 |
|------------------|---------------|-----------------|
| Milk .....       | 1             | tablespoonful.  |
| Cream .....      | 2             | teaspoonfuls.   |
| Milk Sugar ..... | $\frac{1}{4}$ | teaspoonful.    |
| Water .....      | 2             | tablespoonfuls. |

For one portion: to be given every two hours from 5 A. M. to 11 P. M.

Diet from the sixth week to the end of the second month:

|                  |                |                 |
|------------------|----------------|-----------------|
| Milk .....       | $2\frac{1}{2}$ | tablespoonfuls. |
| Cream .....      | 1              | tablespoonful.  |
| Milk Sugar ..... | $\frac{1}{2}$  | teaspoonful.    |
| Water .....      | $2\frac{1}{2}$ | tablespoonfuls. |

For each portion: to be given every two hours.

Diet from the beginning of the third month to the sixth month:

|                  |   |                 |
|------------------|---|-----------------|
| Milk .....       | 5 | tablespoonfuls. |
| Cream .....      | 1 | tablespoonful.  |
| Milk Sugar ..... | 1 | teaspoonful.    |
| Water .....      | 2 | tablespoonfuls. |

For each portion: to be given every  $2\frac{1}{2}$  or 3 hours.

Diet during the sixth month: Six meals daily from 6 to 7 A. M. to 9 or 10 P. M.

Morning and mid-day bottles each:

|                    |   |                 |
|--------------------|---|-----------------|
| Milk .....         | 9 | tablespoonfuls. |
| Cream .....        | 1 | tablespoonful.  |
| Mellins Food ..... | 1 | teaspoonful.    |
| Water (hot) .....  | 2 | tablespoonfuls. |

Dissolve the Mellin's Food in the hot water, and add, with stirring, to the previously mixed milk and cream.

Other bottles each:

|                  |   |                 |
|------------------|---|-----------------|
| Milk .....       | 9 | tablespoonfuls. |
| Cream .....      | 1 | tablespoonful.  |
| Milk Sugar ..... | 1 | teaspoonful.    |
| Water .....      | 2 | tablespoonfuls. |

In the seventh month, the Mellin's Food may be increased to two teaspoonfuls and given three times daily.

Throughout the eighth and ninth months, five meals a day will be sufficient.

First meal at 7 A. M.:

|                  |    |                 |
|------------------|----|-----------------|
| Milk .....       | 13 | tablespoonfuls. |
| Cream .....      | 1  | tablespoonful.  |
| Milk Sugar ..... | 1  | teaspoonful.    |
| Water .....      | 2  | tablespoonfuls. |

Second meal at 10:30 A. M.: milk, cream and water in the same proportions; Mellin's Food, one tablespoonful.

Third meal at 2 P. M. Same as second.

Fourth meal at 6 P. M. Same as second.

Fifth meal at 10 P. M. Same as first.

Mellin's Food may be substituted by Oat Meal or Barley.

#### SODA SOLUTION.

Dissolve one drachm of bicarbonate of soda in a quart of boiled water.

This solution will keep indefinitely if well corked, and a tablespoonful of it equals a tablespoonful of lime water in alkalinity.

#### RULES FOR STERILIZING.

##### *First Method.*

Buy an Arnold's Sterilizer and follow attached directions.

##### *Second Method.*

First. The milk, cream, milk sugar and water for twenty-four hours should be mixed, as soon as received, in a clean, scalded vessel.

Second. The vessel with its contents should be set in a kettle (or sterilizer) of boiling water and allowed to steam twenty minutes.

Third. Pour into the required number of sterilized bottles.

Fourth. Cork the bottles while hot, with cotton, which should not come in contact with the milk. Raw cotton preferred to absorbent.

Fifth. After cooling, place on ice to keep.

*Third Method.*

First. Prepare mixture for the entire day.

Second. Put required amount in each bottle and cork with cotton, which must not come in contact with the milk. Raw cotton preferred to absorbent.

Third. Put bottles in deep tin pail filled with water to neck of bottles. Place on stove and allow to remain for twenty minutes after the water begins to boil.

CARE OF BOTTLES AND NIPPLES.

Cylindrical Nursing Bottles with wide mouths preferred. The bottles should be washed thoroughly in cold water immediately after feeding and set aside full of soda solution.

They should be sterilized immediately before being filled for the next feeding.

Never warm over half used bottles of milk for second feeding—use a fresh bottle.

Plain black rubber nipples, which slip over the neck of the bottle, preferred.

If the hole in the nipple is too small, enlarge by pushing through it a red hot wire. Nipples should be rinsed thoroughly and brushed externally and internally in cold water after feeding, and kept constantly in solution of bi-carbonate of soda.

Very often, in summer, vomiting or acute indigestion is caused by unclean nipples or bottles.

Superstitions are proverbially hard to kill. Among the hardest that I have ever come in contact with is that the grandmother, or an ignorant negro nurse, knows far more about how to feed a child than an educated physician, who has spent a life time in the study of this problem, who has not only his own experience to draw from, but that of the thousands of scientific minds who have preceded him, or who are his co-temporaries along this line of study, and whose combined experiences and deductions were obtained from the close and accurate study of hundreds of millions of babies.



Maybe the time will come when our relative positions will be reversed.

If it ever does, it will surely be a day of hallelujah and rejoicing in babyland.

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### EARLY OPERATION FOR ADENOIDS.\*

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BY ALEX W. STIRLING, M. D., C. M., (Edin.) D. P. H. (London).  
OCULIST AND AURIST TO THE WESLEY MEMORIAL, PRESBYTERIAN  
AND TABERNACLE HOSPITALS, AND TO THE ATLANTA,  
BIRMINGHAM AND ATLANTIC RAILWAY COMPANY,  
ATLANTA, GA.

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It may possibly appear to some that one who in these days ventures to write even a short paper upon the subject of adenoids thereby makes himself a public nuisance, and should at least apologize for his temerity.

It is to be hoped, therefore, that the subject matter of this communication may prove its own sufficient excuse. For in spite of all that has been said of nasal obstruction, I believe that, in relation to the matter upon which I propose to dwell for a few moments, even now its dire effects have not been thoroughly appreciated. I shall pass lightly over the digestive symptoms produced by the swallowing of post-nasal secretions; the fever; the disturbed sleep, due to insufficient aeration of the blood; and the natural attempt to breathe with the mouth shut; the consequent listlessness and aprosexia; the enuresis, explicable on the theory that the nerve centres are dulled as by nitrous oxide, or, perhaps reflex, like the not uncommon hay fever, asthma, and stammering; the enlarged glands behind and perhaps in front of the sternomastoid muscle; the enhanced liability to and danger from such diseases as scarlet fever, diphtheria, bronchitis, etc.; the frequent deterioration of the general health, as shown by anemia, stunted growth, headaches, night sweats, and so on, brought about by a combination of the various ingredients in the pathology of the whole condition, a vicious circle having been set up; the nasal "catarrh" along with the Eustachian infection, middle ear inflammation, deafness, and perhaps mastoid involvement, which we know to be common incidents in the lives of adenoid subjects.

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\*Read before Georgia State Medical Association. April, 1908

This cycle of events is already fairly familiar to all practitioners of medicine, and even the laity is beginning to look upon "asteroids," "aneroids," or whatever may be the name by which they know the offending growth, as one of the numerous penalties which afflict such as uphold the nation by multiplying the family.

But there is one feature of the mouth breathing question which has not yet become nearly so indelibly impressed upon either the medical or the lay mind as it deserves. I refer to the permanent deformities which follow upon it, if it exist while the facial or thoracic bones are still in the plastic stage. These deformities have been, by certain French authorities, laid at the door of rickets, and even syphilis. The latter is certainly a very rare cause, but it may be that there is some relationship between the osseous changes and rickets, while rachitic bones are doubtless especially liable to alteration in shape from external pressure.

In discussing these changes, it may first be stated in general terms that the mouth is related to the digestive, the nose to the respiratory system, and it ought to be looked upon as nearly as outrageous to breathe through the mouth as it would be to drink through the nose. Circumstances make the former, however, an all too common proceeding, and with disastrous, if insidious effects, except when used as an assistance to normal nasal breathing during extraordinary physical effort. As regards the facial deformity, the *crux* of the affair lies with the palate. The palate is moulded into shape mainly by two forces: It is arched by the lateral compression of the buccal muscles; and its arch is broadened and shallowed by the action of the tongue below. At the period of the second dentition, round about the seventh year, and especially in the case of the long-faced types of humanity, the jaws are undergoing a rapid development with a new eruption of teeth in view. Then it is of importance that nothing should interfere with that development. But any form of nasal obstruction will, and adenoids, the result of previous nasal inflammations, constitute the most potent factor in the causation of the pathological events mentioned, though not the only one.

As the air cannot pass freely through the nose, in spite of the instinctive earnest endeavors of the child, the mouth must of necessity be left open. The lateral compression of the facial muscles is thus increased by the strain of the hanging jaw; and

not only that, but the tongue is removed from contact with the palate, upon which in normal circumstances it keeps up a steady modifying pressure outwards, a pressure which is probably more powerful than is generally appreciated.

When the period arrives for the eruption of the second dentition the young teeth must make the best of circumstances, and accordingly instead of appearing in regular contour along the margins of the jaw, they push themselves out in the line of least resistance, each fighting its neighbors for a place, till they may look as if they had been sown broadcast over the *aveoli*. The smile of affection is likely to be modified by the full disclosure of such an unattractive mouth, and the marital prospects of the owner are accordingly diminished. Besides which, the teeth themselves cannot be completely cleaned, and are prone to early decay.

But the evil programme does not end here. The nose is probably also seriously affected, and for a reason which is easily demonstrable. It is like the eye, a double organ, the division being effected through the interpolation of a series of cartilages and bones. These take no note of the pathological process going on in the mouth, and like the teeth, insist upon appearing in their full number and dimensions. But the place to which they have a natural right has been shrunk by the upward arching of the hard palate, and they, too, must perforce squeeze themselves in the best way they can, and that is often a very unpleasant way for their owner. They must be content to undergo contortions which appear to the examining eye as the various forms of deviation, many of which require resection if the nose to which they belong is ever adequately to perform its duty. Thus is set up another segment in the vicious circle which leads to deformity—mouth breathing reacting on itself by continually enhancing its necessity, and making more and more unavoidable operative interference in order that the cycle may be broken. Atrophy of the muscles of the nostril, which should act mildly after the manner of those of the horse, result in collapse and dimpling of the *alae nasi*, and this, combined with the immobile upper and the too prominent lower lip and the open mouth, go to make up what has been called the "adenoid facies."

But the face is not the only region deformed by the action of nasal obstruction. The chest may also suffer in a manner

dependent upon the age of the sufferer. After the osseous tissue becomes well established in the ribs and sternum, the effort to breathe normally through the mouth results merely in a flattening of the chest walls, and an indrawing of the inferior portion of the sternum. But in earlier years the tendency is to the formation of "Harrison's (transverse) furrow," and to the depression of the costal cartilages, with prominence of the sternum, called "Pigeon-breast," which is likely to be more marked the more vigorous the effort to breathe through the nose. And this difficulty of breathing is increased by enlargement of the faucial tonsils. The *modus operandi* of the deformity is apparent enough. A child will always do his utmost to breathe through his nose, even when his mouth is open, before the mouth breathing habit has been finally established. The result is often stridor, sometimes mistaken for croup, and, of course, an indrawing of the delicate walls of the chest, which in time becomes permanent.

The effects of mouth breathing, I think then you will agree with me, are not only powerful to destroy the healthy contour of the face and chest, but may also bring in their wake such danger and suffering as indicate early operation for their prevention.

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## HYDROCELE AND SPERMATOCELE, WITH REPORT OF CASES.\*

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BY W. L. CHAMPION, M. D., ATLANTA, GEORGIA.

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Hydrocele, or an accumulation of fluid in the tunica vaginalis, being a condition we are so frequently called upon to relieve, so easily recognized, and as a rule, so successfully cured by the injection of carbolic acid, I desire to report fifty-one cases taken from my record book; and also to include, on account of its rarity, three cases of spermatocele.

When there is an accumulation of clear serous fluid in the tunica vaginalis, it is termed hydrocele; when the fluid contains blood, hematocele; and when spermatozoa are present, spermatocele. There are several varieties of hydrocele: acute, chronic, multilocular, congenital, infantile, inguinal, and hydrocele of the

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\*Read before Medical Association of Georgia, Fitzgerald, April 15, 16, 17, '08

spermatic cord. In this short article the various kinds will not be described,—only dividing hydrocele into two classes: symptomatic and idiopathic.

Symptomatic hydrocele follows a diseased testicle; idiopathic hydrocele develops without any known cause, or, not knowing the cause, this name is applied to the condition.

In the report to follow, ten of the fifty-one cases did not have any disease of the testicle or epididymis, nor did they give a history of gonorrhea or syphilis. The fact that so few males escape venereal diseases, and the possibility of injury being the cause, all hydrocele might be classed as symptomatic. With the patient in a dark room and a light behind the tumor, diagnosis is easily made if the fluid is clear; if not translucent and eliminating hernia, a hypodermic needle inserted will clear up the diagnosis; unless the hydrocele is very large, the testicle can be felt to determine whether it is sensitive, hard, enlarged, or nodular. As a rule when a testicle is syphilitic there is fluid in the tunica vaginalis. In small hydroceles incision, aspiration or tapping will occasionally perfect a cure, but in large tumors after tapping without injection, the fluid will gradually accumulate.

Casper, in his text-book on genito-urinary diseases, states that the procedure of tapping and injecting irritating substances, such as tincture of iodine and carbolic acid, is not absolutely certain nor without danger; therefore, he favors the more radical operation by means of open incision.

Green and Brooks, in their recent work on diseases of the genito-urinary organs, state: "It has been a common custom for a great many years to inject into the sac through the trocar, a few drops of a powerful destructive agent, with the object of setting up an adhesive inflammation between the walls of the tunica that will cause them to adhere and thus prevent the reformation of fluid. This method is sometimes successful, but personally the writers prefer one of the radical operations,—that is incision." I have never seen any bad results nor toxic effects from the use of carbolic acid, and have injected a dram of the acid in a hydrocele sac. Keyes, in late edition on genito-urinary diseases, says: "After using carbolic acid injections in many cases ranging in age from two months to eighty years, in no case has any complication or serious reaction occurred in his hands."

I do the operation in the office, first cocainizing the part to be punctured, which makes the operation painless, with the exception of the first effect of acid, which is a severe smarting pain lasting perhaps for a minute. Before introducing the trocar, the testicle should be located, so as to avoid injuring it. Some operators after emptying the sac through the canular, inject the acid with a hypodermic syringe, inserting the needle at a location distant from the opening made to withdraw the fluid. The needle is inserted before the fluid is drawn off; after the fluid escapes through the canular, the syringe containing the acid is attached to the needle and acid injected.

I prefer to empty the sac and inject twenty to thirty minims of the pure acid through the canular in the position it is in when the fluid is drawn, connecting the syringe with the canular, or preferably, using a needle a fraction longer than the canular, and passing it through the canular to the bottom of the sac, thus preventing the acid from coming in contact with the skin or escaping into the tissues. Before injecting the acid, care should be taken to remove all the fluid, as a small quantity left in the sac may cause the operation to result in failure. Immediately after injecting the acid, remove the canular and knead the scrotum so as to distribute the acid over the surface of the sac. Close the puncture with collodion, and request the patient to remain at home for twenty-four hours, as there will be some soreness and swelling due to reaction. A suspensory bandage should be worn until the scrotum resumes its natural size.

I believe the operation will always result in a cure without any complications if aseptically done, except in cases where the walls of the sac are very much thickened or the accumulated fluid results from syphilis or tuberculosis of the testicle.

Of the fifty-one cases here reported, twenty-eight had gonorrhoea, or gave a history of the disease; ten gave no history of gonorrhoea or syphilis; eight had syphilitic involvement of the testicle; four were tubercular; and one cancerous. Three of the cases were taped and never reported again. In three of the syphilitic cases injected, the fluid returned and they were injected again after being on anti-syphilitic treatment for a few months. After tapping a hydrocele, if the testicle is found to be enlarged, hard and irregular in shape, indicating syphilitic or

tubercular condition, it is useless to inject carbolic acid. The patient should be put on proper treatment for such condition, and if the testicle is syphilitic, the hydrocele as a rule will disappear as the testicle becomes normal.

It is rare to find a cyst springing from the testicle or fluid in the tunica vaginalis containing spermatozoa. This condition is termed spermatocele, and is produced by inflammation of the seminiferous tubules, thus causing retention of the semen in the constricted tube forming cyst. Should the cyst rupture into the tunica vaginalis, the condition resembles hydrocele. On account of its rarity, without giving a detailed report, I mention three cases that have come under my observation. Two of the cases consulted me account of an enlargement of the testicle. The first case in 1904, and the other in 1907. Both cyst were small, containing five or six drams of fluid alive with spermatozoa, and were cured by incision. The third case was seen by request of Dr. L. A. Fowler, at the Federal Prison. About two ounces of fluid of a milky appearance was drawn off, which under the microscope showed the field swarming with spermatozoa.

313 and 314 Prudential Building.

#### References:

*Surgical Diseases of the Genito-Urinary Organs.* E. L. Keys. 1903.

*A Text-Book of Genito-Urinary Diseases,* Dr. Leopold Casper, 1906.

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### TREATMENT OF SPRAINS.\*

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BY THEODORE TOEPEL, M. D., LECTURER ON MEDICAL GYMNASTICS  
AT THE ATLANTA COLLEGE OF PHYSICIANS AND SURGEONS,  
DIRECTOR OF PHYSICAL EDUCATION IN THE ATLANTA PUBLIC SCHOOLS, MEDICAL EXAMINER AT THE ATLANTA  
ATHLETIC CLUB.

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Sprains are the most common form of injury to a joint. A sprain is a wrenching of a joint, producing a stretching or laceration of the ligaments. It is most frequent in the wrist, knee, and ankle joints. It may be slight and the symptoms subside quickly, or it may be severe and of uncertain length of duration.

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\*Read before the Georgia Medical Association, Fitzgerald, April 15, 16, 17, 1908.

The synovial membrane is compressed on one side, while on the other it is unfolded, stretched or torn. Ligaments are usually stretched on one side only. Some of the fibres are torn, and sometimes the whole ligament may be detached from its osseous attachment, and even small parts of the bone may be torn off.

There is more or less laceration of vessels with attendant hemorrhage into the joint cavity and the surrounding tissues, in consequence of which the limb in a few days becomes discolored for some distance above and below the joint.

The sprain is rapidly followed by swelling and inflammation of the joint and investing tissues, often very chronic and tedious. As the inflammation subsides, stiffness and pain in using the part continue for a considerable length of time, and are in some cases followed by rigidity and wasting of the limb. In individuals of a rheumatic or gouty habit of body, the inflammation of the joint resulting from the sprain is often most tedious and chronic, and will yield only to appropriate constitutional treatment. In strumous subjects, destructive disease of the joint may ultimately be induced.

Upon the receipt of a sprain and if, after a careful examination, you find no fracture, immerse the part in hot water, or have hot compresses applied for one hour, or place the part in a dry hot air apparatus and expose it to the dry hot air, the temperature being about 300-F, for one hour, to relax the tension, then treat with massage, beginning with gentle friction, gradually increasing in force (as a peripheral nerve sedative), follow with gentle kneading, long continued, beginning at a distance from the injury and gradually approaching it. End with palmar percussion. Bandage tightly with wet bandage, then order ice bags to reduce the inflammation, and insist on perfect rest. Keep the joint elevated for twelve to twenty-four hours, in order to limit the formation of passive congestion in or around the joint.

On the second day, repeat the treatment of first day, omit ice and add passive circumduction and passive flexion and extension. On the third day, use treatment of the first two days with resistive movements added. Encourage activity between treatments after the second day. Remove the bandage permanently the third or fourth day. A light sprain takes from seven to ten days to cure, though one of hip and shoulder requires longer time, and it is safer not to use them for one week.



Except in cases of unusually severe sprains, where ligaments are torn or detached, movements of the joint, passive, active and resistive in their order, when properly supported, are very beneficial. When there is much effusion in the joint, the limb should be kept elevated, and active motion of the joint suspended until the effusion has subsided. If the injury has been severe, where tendons have been torn across or have become detached, and the part is very sensitive to motion or jar, the joint having been protected with gauze, is fixed in a light plaster bandage. This is cut after the eighth day, to allow for daily massage and exposure to hot air, which is of great service in hastening the absorption of the effusion. Care must be taken to return the limb to the cast after each treatment in exactly the same position as when the cast was first moulded to the part. In most cases, this procedure must be continued for about four weeks. I consider this method superior to that of applying adhesive strips, where the physician is unable to do anything more for his patient, who in many cases is left to rely upon nature to effect a doubtful cure. The use of massage and hot air is of great service in relieving the discomfort, and especially in stimulating the circulation of the blood, upon which repair depends. As soon as practicable, begin the use of active and resistive exercise to prevent stiffness and to strengthen the weakened tendons and ligaments. Resistive exercises are especially indicated in this condition, because of the necessity of localized movements, which must be confined to the afflicted tendons and ligaments.

A chronic sprain may be the result of an inefficiently treated acute injury, in which an improper attitude, originally assumed to spare the sensitive part, finally becomes habitual. In other instances, persistent disability may be the result of fixation of the joint for too long a time in splints. Such disuse causes atrophy of the muscles and of the bones as well, while the effused material within and without the joint remains, because of the improper circulation. The same disability may follow simple disuse of the injured part. It is more often observed in nervous individuals, who exaggerate the importance of the injury, and the discomfort that it causes. In such cases, the limb may be discolored by venous congestion, the part may be œdematous, and the movements may be limited by adhesions, or by muscular adaptation to the habitual attitude.

Treatment of chronic sprains must be conducted with the aim of restoring the normal range of motion and so supporting the part that normal functional use may be permitted. If adhesions have formed, and if the part is persistently held in an abnormal attitude, forcible manipulation under anæsthesia may be required as a preliminary treatment, followed by fixation for a time in a plaster bandage, in the attitude directly opposed to that which has been habitual. When all discomfort has disappeared, a support should be worn for a time. The most effective after treatment is passive and active exercise.

In conclusion, allow me to say that notwithstanding the fact that the traditions of the profession required absolute rest of the affected parts after injury to the joint, we now know conclusively, that massage and then exercise applied early and with a suitable degree of skill and perseverance, effects a more speedy cure in most cases of sprains than absolute immobility, and prevents both the loss of movement which usually occurs, and the muscular atrophy which is the natural result of absolute rest and immobility.

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### CRUSHES OF THE EXTREMITIES.\*

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BY THOS. H. HANCOCK, M. D., ATLANTA, GA.

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These accidents may occur in the country or small towns, and the rule is to take them to one of the cities. This may be a good procedure in many cases where the loss of blood has not been great and the shock is not marked, but even the crushes of the arm, fore-arm or foot should not be neglected, as many of them have proved fatal.

Since we may have such an accident out in the country entirely away from a physician, the layman should know how to control hemorrhage. Constriction of the limb just above the injury is easily made by a piece of bell cord, a suspensor or a handkerchief. The mistake usually made is that they are not tight enough, and a moderate compression increases the venous flow. These improvised tourniquets become very painful, even when they are applied near the crushed area, *and may add to the shock, if left too long.* Whiskey *in moderation* will be a great help until

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\*Read before Medical Association of Georgia, Fitzgerald, April 15, 16, 17, '08

the physician arrives, when he can give a few whiffs of chloroform, if he knows how to give it; or ether, if he does not, as all doctors can give ether. Then he can easily cut away the mangled tissue and tie the most of the bleeding vessels. If he is embarrassed by any bleeding points which he cannot catch, he has simply to thread a curved needle with a piece of catgut and take a stitch through the tissues in such a manner as to include the vessel. (I have tied the superficial palmar arch in this way). The hemorrhage having been controlled, the wound should be irrigated with an antiseptic solution and dressed with gauze wet with a 1-3000 bichloride solution, and the ordinary dressing applied over it as a temporary dressing.

Now, after extensive crushes we have to fight against shock. The body must not only be treated but also the mind, and we can do much by reassuring them. The pain can be relieved by sulphate of morphia, which in small doses is a stimulant, but in large doses depresses. The dose should be from one-eighth to one-quarter of a grain hypodermically, and it may be repeated at intervals of an hour, if necessary. I have seen two cases that I am satisfied were killed by too large doses of morphine; and in one of the cases the physician acknowledged having given a grain hypodermically, as he said "the patient was restless and very hard to control." The restlessness never kills.

The head should be lowered and hot water bags or bottles (the latter can always be had) should be put around the body, which should be well covered. There is little use in putting medicine in the stomach, as it will probably be vomited. Warm salt solution thrown into the bowel does equally as well, if not better, than that given by infusion. An enema consisting of a pint of the normal salt solution to which has been added an ounce or two of whiskey and several ounces of black coffee will be found to be very effectual. Larger amounts of the solution are not so apt to be retained. The patient should be kept quiet, and should not be moved any considerable distance if shock is marked. The amputation may be postponed for several days if necessary.

This is one of the conditions; the other is that of the patient who has been injured close to a hospital where everything is in readiness for an immediate operation; both thighs possibly have been crushed, but in a short time he is on the operating

table. The morphia (1-8 of a grain) and enema have been given. The anæsthetic has been commenced, and in less than an hour the patient is in a bed with the foot elevated, the hot water bags are about him and reaction soon begins to take place. The last two cases I have seen of double crushes of the thighs have recovered, and in both cases two of us operated at the same time. Drainage should always be used and an iodoform gauze dressing will prevent the early decomposition of the secretions. It should be changed, however, in twenty-four hours.

Three grains of the mild chloride of mercury should be given as soon as reaction has been established, and this should be followed in eight hours by half an ounce of Epsom salts, which should be repeated every four hours till the bowels have acted well. Should the third dose prove ineffectual, an enema consisting of half an ounce of fee bovis and half a pint of glycerine with a quart of warm water should be given. The diet is an important factor.

If he is in a hospital, he will be put on a liquid diet, but he does not always get it, as milk is on this list. Unmodified sweet milk drunk by the glass curds in the stomach in a large curd which is hard to digest and predisposes to flatulence. It is almost universally given and I mention it only to condemn it. If it is drunk through a nipple or a small pipette, very slowly, as suggested by Dr. Harris, it may be very good. Many of its modifications are very valuable, and especially is this so of malted milk and many of the creamed broths. Mixed vegetable soups containing meat fats are also bad. Various meat broths, albumens and other prepared foods may be had which will give variety and will answer every purpose.

His whiskey should be kept up indefinitely, if he has been a drinking man; and if he is a cigarette smoker, pity him and let him have cigarettes in moderation. Also, if he has any drug habit, reduce it gradually. The small things in our work often decide the result.

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The thirteenth annual meeting of the Association of Surgeons of the Southern Railway Company was held at the Hillman Hotel, Birmingham, Ala., April 28, 29 and 30, 1908.

## THE IMPORTANCE AND SCOPE OF REMEDIES INCREASING THE ACTIVITY OF THE LYMPHATICS, WITH SPECIAL REFERENCE TO IODALBIN.

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BY NOBLE M. EBERHART, M. S., M. D.

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Prof. & Head of Dep't of Electro-therapy, Chicago College of Med. & Surgery; Prof. High-frequency & Vibration, Ill. School of Electro-therapeutics; Attending Surgeon, Frances Willard Hospital; formerly Attending physician Cook County Hospital.

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In the treatment of diseased conditions a fact that is often overlooked or underestimated is the importance of the lymphatic system.

A great deal of stress is laid upon the blood and its components and upon various bodily functions without due consideration being given the role played by the lymphatics.

It is through the medium of the lymphatics that nutritive elements finally enter the blood and the tissues, and the waste products from the latter find their way out of the system.

It therefore follows that the successful treatment of any pathological condition will be materially aided by proper attention to the lymphatics, keeping them active and unobstructed.

Their importance from a therapeutic standpoint has received more consideration since the subject of mechanical vibratory stimulation has attained its present prominence, its results having been shown to rest, outside of stimulation of nerve centers, largely upon its effect as a lymphatic stimulant.

Aside from vibration, we have other useful means of acting upon the lymphatics, and omitting consideration of the various measures included under the head of physiological therapy, we come to the consideration of some of the medicinal preparations.

These were formerly known as alteratives and were supposed to influence the body in some mysterious way. It would

seem, in the light of our present knowledge, that nearly all of these remedies are medicines which directly increase glandular activity and thus aid metabolic processes and increase the elimination of poisonous or waste products.

Among remedies which have stood forth prominently in this line, have been iodine and the iodides, the sulphides, phytolacca, etc.

Of these the one which has been used more than all others has been the iodide of potash. It has been uniformly satisfactory in results where its administration has been tolerated by the system and the principal drawback to its use in a much larger field has been the gastric irritation and the development of iodism, which so frequently follow its use.

It has therefore been restricted largely to use in secondary and tertiary syphilis, although it would otherwise be applicable to a wide range of diseases.

Under these conditions it is but natural that we should welcome any preparation which offers the opportunity of introducing iodine into the system in assimilable form and unaccompanied by unpleasant before or after effects. This is claimed to be the property of iodalbin.

Iodalbin is an almost tasteless, reddish powder, containing  $21\frac{1}{2}$  percent. of iodine in combination with albumen, thus being an iodine-proteid compound.

It does not dissolve in water, acids or alcohol, but is freely soluble in alkaline solutions.

Its insolubility in acid solutions ordinarily prevents breaking up in the stomach and consequently gastric irritation is rare.

When iodalbin reaches the alkaline intestinal secretions, it dissolves rather slowly and thus the absorption is slower than with iodide of potash, but since the iodine is in an organic combination it is much more thoroughly taken up and less passes out unappropriated.

In this manner the exaggerated effect following the rapid absorption of the alkaline iodides is obviated, but the final result is a more complete and thorough taking up by the system of the iodine which undoubtedly accounts for the fact that iodalbin with  $21\frac{1}{2}$  percent. of iodine apparently gives better results than iodide of potash with 76 percent. of iodine.

I have stated that iodalbin does not ordinarily produce gastric irritation. Granting that it remains stable in an acid medium, it would obviously have no opportunity of producing irritation of the stomach under ordinary conditions, thus being far superior to the alkaline iodides.

In two cases I have found that irritation of the stomach was undoubtedly produced by iodalbin, even when taken carefully as directed, an hour after each meal, followed by a full glass of water.

In giving this matter due consideration, it has occurred to me that in these cases where irritation is produced there must be necessarily a temporarily alkaline condition present in the stomach to admit of the breaking up of the compound and consequent absorption, and irritation of the gastric mucous membrane.

Under these circumstances, I would suggest that the stability of the iodalbin while in the stomach be insured by the adding of a few drops of hydrochloric acid to the glass of water with which the capsule is swallowed.

It stands to reason that any compound containing iodine may be taken in sufficient quantities, or under such circumstances that iodism may result; and that this does not occur frequently with iodalbin is a clinical fact which I attribute to a much better, though slower, assimilation of the iodalbin, so that the physiological effects do not ordinarily tend to become pathogenic.

The system can appropriate large quantities steadily administered before iodism occurs; while the sudden taking up of a large quantity will produce this symptom. Alkaline iodides being thoroughly soluble, the initial absorption is apt to be in the nature of a temporary overdose, and the balance passes out with the excrement entirely unabsorbed. Thus we sometimes have too great an effect with part of the dose and none whatever with the remainder. In iodalbin, we have slow, steady absorption of an organic compound, with its action always under control.

I have used iodalbin in specific conditions with uniformly satisfactory results, but in this article I am especially desirous of bringing out the point that it is not so much to be considered merely as a substitute for potassium iodide in syphilis, but that owing to its thorough assimilation and comparative lack of objectionable after or by-effects, it gives opportunity for its use in a host of conditions where iodine is of advantage but many

times unemployed. I refer to rheumatism, neuritis, asthma, arterial sclerosis, psoriasis, goitre, chronic bronchitis, anterior poliomyelitis and in obscure conditions where nutrition and elimination are interfered with without a precise diagnosis being easy or possible.

The usual dose is from 5 to 15 grains given an hour after each meal and preferably followed by a full glass of water. I have given 60 grains a day without producing untoward symptoms.

I have always used the 5 grain capsules for convenience.

As my special work is electro-and-radio-therapy, it is but fair to state that in most cases I have used physiological methods in conjunction with iodalbumin. I give herewith a few cases selected from a number treated.

CASE I. Mrs. A. An artist working constantly at burning wood and leather, using a point heated after the manner of a Paquelin cautery but using wood alcohol in place of benzine as a fuel.

Breathing in the hot fumes of the wood and leather, at first made the lips dry and chapped and finally an intractable sore appeared on the lower lip which had existed for a number of weeks when I saw the case, and had resisted the local use of several washes and powders.

I was uncertain of the precise character of the sore, but continued the use of local antiseptics, applied the leucodescent light and vibrated cervical lymphatics, and cervical and dorsal spinal centers.

At the end of a month the improvement was very slight, but no additional symptoms had developed to give a possible clue to the diagnosis.

At this time I began the use of Iodalbumin on the general hypothesis of increasing elimination through the lymphatics (which although slightly congested presented no marked enlargement or induration.)

I commenced with two capsules, an hour after each meal, followed by a full glass of water.

In a few days the sore began to heal rapidly and disappeared within two weeks.

CASE II. Mr. X. A case of locomotor ataxia receiving



vibrations and high-frequency currents to improve locomotion and relieve the pains, gave evidence of the need of iodine for some manifestations of the specific origin of his present disease.

Prescribed two capsules an hour after each meal. Patient complained next day that his stomach had been entirely upset by one dose of the medicine. I did not think it possible and ascribed it to other causes and requested a further trial, using a single capsule with same results, so iodine was discontinued, as at this time the idea of using dilute hydrochloric acid had not occurred to me.

CASE III. Mr. Y. Tertiary syphilis with marked idiosyncrasy to potassium iodide.

I started with one capsule of iodine given an hour after each meal with a full glass of water. In one week I increased to two capsules and the third week to three capsules.

The condition of the patient rapidly improved with no indication of iodism until after several weeks on the full dose, when symptoms appeared, but subsided quickly on stopping the medicine.

This patient was under treatment a number of months and I found that one capsule three times a day for one week increasing to two the second week and three the third, maintaining the latter for three, four or five weeks, followed by a change to vegetable remedies (Echinacea, Baptisia and Phytolacca), for two or three weeks and then a return to the iodine kept the disease down to the mutual satisfaction of the patient and myself.

CASE IV. Mr. Z. Case of neuritis involving upper branches of anterior crural nerve, left side. The burning pain was very annoying and persistent.

Electrical and vibratory treatment afforded partial relief and on the addition of iodine, two capsules three times a day, marked improvement was noted.

CASE V. In a patient suffering from an old injury to the knee-joint, with fibrous ankylosis considerable pain of a rheumatic character was frequently present and persisted after the mobility of the joint had been restored. After the use of the salicylates and other remedies iodine was resorted to, one capsule three times a day, increasing in one week to two capsules.

The pain was somewhat relieved, but did not disappear and after three weeks the iodolbin was discontinued.

I cite this case because one must not expect to get uniformly successful results with every remedy and it is important that failures as well as successes be reported that the profession may not form an entirely one-sided view of any preparation or method.

CASE VI. Mr. R. Chronic bronchitis with scanty expectoration. Two capsules of iodolbin three times a week produced quick and thoroughly satisfactory results.

A number of similar cases could be cited, and the remedy as I believe, especially satisfactory in these cases. The dose should be increased if necessary.

72 Madison street.

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The seventy-sixth annual meeting of the British Medical Association will be held at Sheffield, in July.

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Plans are outlined for the enlargement of the work of the Tabernacle Infirmary and Training School for Nurses, which is one of the departments of the Tabernacle system of institutional church work.

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The Tennessee State Medical Association held its seventy-fifth annual meeting, at Knoxville, April 14, 15 and 16, 1908.

The following officers were elected: President, Dr. B. D. Bosworth, Knoxville; vice-president for east Tennessee, Dr. C. T. Carroll, Cleveland; vice-president for middle Tennessee, Dr. J. W. Brandau, Clarksville; vice-president for west Tennessee, Dr. W. T. Blanton, Union City; secretary, Dr. George H. Price, Nashville; treasurer, Dr. W. C. Bilbro, Murfreesboro; delegates to American Medical Association, Dr. S. W. Woodyard, Greenville; alternate, Dr. George R. West, Chattanooga, for 1908; for 1908-9, Dr. S. S. Crockett, Nashville; alternate, Dr. K. S. Howlett, Franklin. Next place of meeting, Nashville; time, April

# EDITORIALS

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## EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.

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The importance of an early diagnosis of pulmonary tuberculosis is so evident to those treating phthisis, and its neglect so common that an excuse for its consideration editorially is not necessary.

When well developed no difficulty whatever is encountered in making a prompt diagnosis. By this time, however, we meet almost insurmountable difficulties in the treatment. The effect of therapeutic measures in its incipency compared to those when the disease is well developed justifies great stress upon its early recognition.

The demonstration of tubercle bacilli in the sputum is a diagnostic sign of indisputable accuracy, but also means that valuable time has been lost—time in which more sanguine hopes of recovery could have been entertained.

Lawrason Brown\* has recently called attention to the question of early diagnosis, and asserts that tuberculosis can often be recognized by the symptoms alone, and that the diagnosis must often be so made; for even when the lesion is in the lungs the localizing symptoms may long remain absent. Petruschky distin-

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\*Albany Medical Annals, April, 1908.

guishes three stages: first, involvement of the bronchial glands; second, involvement of the lung before ulceration; third, the breaking down of the disease focus. Brown insists that pulmonary tuberculosis can exist without producing any physical signs; not that he belittles the importance of physical signs, but urges that we be careful in excluding tuberculosis because no physical signs are present. He has found them characterized, though, chiefly, by their absence, by their occurrence with symptoms, often so slight as to escape our notice, by their slowness even when symptoms have been of long standing, by their variation and evanescence, and by their sudden appearance. They constitute but one of the links in the diagnostic chain.

A careful history and a consideration of the surroundings, failing health and physical signs, if present, often contribute a typical picture.

Rales that can be heard no other way can be made much more apparent by having the patient cough. Occasionally, however, this may cause the rales to disappear.

He thinks that the time will come when the physician who waits for the tubercle bacilli to occur in the sputum will be looked upon as a man deficient in diagnostic acumen and one dangerous for public health. When all known procedures have been carried out and doubt as to the diagnosis still exists the tuberculin test should be suggested. A positive reaction does not prove that the focus is in the lungs, nor does it prove that an apparently healthy individual needs treatment; but when a patient with symptoms suggesting tuberculosis reacts to tuberculin, a course of treatment should be insisted upon.

McClelland\* reports one hundred observations with ophthalmic reaction to tuberculin as introduced last summer by Calmette, of the Pasteur Institute of Lille, as a diagnostic test for the presence of tuberculosis.

It is claimed for this method that it is absolutely safe, easy of application, produces no constitutional disturbance and that it is as accurate as the hypodermic injection if not more so.

The Calmette tuberculin is used in a 1% solution in distilled water. One minim of this is instilled in the inner half of

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\*British Medical Journal, December 7, 1907.

the conjunctiva. In from three to ten hours, if the reaction be positive, a redness of the conjunctiva is seen. This varies from a slight injection near the caruncle to redness over the entire eye with the symptoms of a conjunctivitis. Of course ocular lesions, either acute or chronic contra-indicate its employment.

The analysis of McClennan's cases brings out the facts:

(1) That for the most part the claims advanced by Calmette for his test are fully justified; (2) that the test apparently reveals the presence of tuberculous lesions that are quite benign and unsuspected from a clinical point of view, as well as those that are more obvious; (3) that in those cases in which a subcutaneous injection of "old" tuberculin has given a positive or negative reaction the same result has followed the application of the opthalmic test; (4) there seems some evidence that a solution of the "old" tuberculin may answer equally well.

If this test proves, on further experience, to be reliable, it will be a valuable aid to the early diagnosis in obscure cases. It is now believed that this test is equally as reliable as the hypodermic test, and one worthy of trial.

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### MAGIC HEALER, NOT A PHYSICIAN!!

Of far-reaching significance to the medical profession is the recent decision of the court of appeals, that a "Magic Healer" is not a physician in the sense of being required to pay license to practice medicine in the State.

Judge B. H. Hill rendered this decision in the case of *Bennett v. Ware*, which was appealed from the city court of Fitzgerald.

A. D. Bennett advertised himself as a "magic healer," stating that he could cure by laying his hands on the diseased or sick persons, and that he had "magic power given direct from the Lord."

D. B. Ware swore out a warrant charging him with practicing as a physician without having paid his license fee. Upon preliminary hearing Bennett was discharged from custody, and thereupon brought suit for damages against Ware for malicious prosecution. Bennett lost his suit in the lower court, and the court of appeals upholds that decision.

To hold that such an individual as Bennett is not to be

regulated by the medical practice statutes of Georgia, to all intents and purposes, renders the present medical laws of the state worthless and opens wide the gate for quacks and charlatans of all descriptions to swoop down upon us, unhampered by any restrictions.

At the present time when so many important measures aside from drugs, are being used by regular physicians in curing disease and when *diagnosis* is recognized as absolutely necessary to successful practice, not only by physicians but by laymen of ordinary common sense, it seems incomprehensible that Judge Hill should have handed down such a decision. Is not a physician practicing medicine who recognizing incipient tuberculosis, advises the open air treatment and liberal feeding, without the administration of any medicine whatsoever? Is not the dermatologist practicing medicine who cures a cancer with X-ray? Is there a measure used by physicians or quacks with which greater harm can be done to a patient than with the X-ray ignorantly used? Shall we allow charlatans who know nothing of disease and less of such a curative measure to slaughter trusting patients with it? Shall osteopaths and Christian Scientists be allowed to treat patients for ailments they cannot diagnose, simply because they do not administer drugs and medicine?

If the law is intended to prevent an incompetent physician from having charge of the sick is it not all the more important that it should prevent an admitted imposter from assuming these duties? It is a strange law that intends to protect the people from incompetent medical attendance and yet does not apply to a quack who assumes the duties of a physician.

The law (according to Hill), renders *him* immune because he is *not* a physician. The very fact that he is not a physician makes the necessity of a law all the more urgent. According to Judge Hill's decision a lawyer may treat the sick, as long as he eschews medicine, not because he knows anything about the disease he has charge of, but because *he is a lawyer* and cannot be regulated by the law intended for physicians.

One would think there could be no debating the fact that the medical practice law should protect the sick from imposters no matter what their profession or methods. It is just as rational to expect a broken automobile to run by saying a few incantations over it as to think that an imposter can cure a patient by "laying on of hands." In each case the determination of what the trouble is, must be the first step in the correction thereof. Diagnosis is

therefore an integral and essential part of the curing of disease regardless of the measures employed.

Such a decision will bring to our State a swarm of new "systems of practice," which no matter how absurd their claims or how dangerous their methods, cannot be affected by the law so long as they *use no drugs*.

Can you imagine a more illogical, intolerable position? Infectious diseases will be unrecognized, and therefore unchecked in their course of disaster and death. Patients will be robbed of their health as well as money and a premium placed upon cupidity and quackery. Is it not time for the medical profession to make an organized effort to obtain a sensible decision defining the practice of medicine?

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#### TO PREVENT OPHTHALMIA NEONATORUM.

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The first conviction under the law recently passed in Baltimore to prevent infants from becoming blind was obtained in the criminal court March 27. Mrs. Mary Fogler, a midwife, was found guilty of violating the law and was fined \$25.00 and cost, amounting to \$43.00.

The law in question provides that if at any time within two weeks after the birth of an infant one or both of its eyes or eyelids be reddened or inflamed, the nurse or person in charge of the infant shall refrain from the application of any remedy, and shall report immediately such condition to the Health Commissioner or a qualified physician. The penalty for violating the law is a fine not exceeding \$100, or imprisonment in jail for not more than six months, or both fine and imprisonment.

It was shown by the testimony that Mrs. Fogler attended Mrs. Mary Conway, 1610 Burroughs street, whose child was born February 6 last, and the infant had lost the sight of one eye. Mrs. Conway testified that when the infant's eyes became affected Mrs. Fogler told her not to get a doctor, and the case was not reported to any physician. Finally the child was taken to a hospital and the prosecution of Mrs. Fogler followed.

According to Mrs. Fogler's own statement Judge Wright said, in deciding the case, she had violated the law by not reporting the case to a physician. Her want of knowledge, or re-

fatal to obey the law, the Judge added, had caused the child to become blind in one eye. As it was the first case of the kind to be tried, the maximum penalty was not imposed.

There are few diseases in which disaster is more likely to follow delay in treatment than in gonorrhoeal ophthalmia, and the publicity given to such cases will be of great value in educating mothers as to the danger of sore eyes in an infant, and to the necessity of a careful examination at the incipency of all such conditions.

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### LIBERAL AND SENSIBLE CONSTRUCTION OF THE PROHIBITION LAW.

The court of appeals rendered a sensible decision in reversing the construction of the lower court in regard to medicines, culinary and toilet articles. Undoubtedly this view will strengthen rather than weaken the present law, as it will increase the general respect for the law in that it carries out its intent and purpose. The court held that the intent of the legislature in enacting the law was to prevent the evils of intemperance caused by the use of intoxicating liquors as a beverage.

The court also held that the phrase "place of business," as used in that section of the act prohibiting the keeping of liquors in such places, meant a public place of business in contra-distinction to a place of private business.

In conclusion it says: "Prohibition is not a crusade against medicine, culinary or toilet articles, or those beverages which cannot intoxicate. These things are necessary to life, health and comfort. Prohibition is a crusade against intoxicating liquors as a beverage, and the resultant evils of intemperance."

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### THE MOSQUITO PEST.

It will certainly be an unwise policy for the city authorities of Atlanta to allow the mosquitoes to become unnecessarily numerous this summer on account of the shrinkage of the city's.



income. The curtailment of appropriations should not affect the \$5,000 necessary to annihilate the mosquitoes by attacking their larvae. This may be done by coating the water with crude oil. It is hoped that when Dr. J. P. Kennedy explains the situation to the Finance Committee that they will see the urgent need of this appropriation to carry on the war against the mosquito.

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#### THE PAPERS AT THE RECENT MEETING OF THE MEDICAL ASSOCIATION OF GEORGIA.

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On looking back a decade or so to the meetings of this Association, the impartial observer is happily impressed with the change which has taken place in the general character of the contributions to the scientific aspect of these gatherings. Then though there were some excellent discourses, one was not yet usually exactly spell-bound by what one listened to. Now there is something to be proud of. There are clear traces of originality, thought, and earnestness in no inconsiderable proportion of the papers presented. It would be foolish to plume ourselves on present achievements for there is much, very much, still to criticise in the medicine side of life in Georgia. But movement is clearly forward and upwards, and hope is well grounded. In the mean time there are a few men among us who are doing first-class work as investigators, and a considerable number who are building up a high reputation for themselves and their state. Excelsior!

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#### NEWS AND NOTES

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An international committee has been appointed to take charge of the awarding of the medal to be awarded periodically as a memorial to Schaudinn, to the individual who has contributed most to the progress of microbiology.

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On May 19th the alumni of the medical department of Tulane University propose giving a jubilee to celebrate the anni-

versary of the fiftieth year of teaching service of Prof. Chaille. On this occasion it is proposed to announce the establishment of a Chaille Memorial Fund, created to memorialize the occasion of Dr. Chaille's retirement from the medical department and to perpetuate his name.

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"Dr. A. N. Richards of the College of Physicians and Surgeons of New York City has been appointed professor of Pharmacology in Northwestern University Medical School."

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Dr. John B. Murphy has resigned as Professor of Surgery and co-head of the Department in Rush Medical College and has accepted the Professorship of surgery and head of the department in Northwestern University Medical School and position of attending surgeon at Mercy Hospital."

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"Dr. A. W. Meyer of the University of Minnesota and formerly of Johns Hopkins has accepted the professorship of Anatomy in Northwestern University Medical School."

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At the thirty-fifth annual meeting of the Florida Medical Association, held in Ocala, April 15-17, the following officers were elected: Dr. James F. McKinstrey, Jr., Gainesville, president; Drs. James, Dr. Love, Jacksonville, and William H. Powers, Ocala, vice-presidents; Dr. J. D. Fernandez, Jacksonville, secretary-treasurer (re-elected); Dr. Charles E. Terry, Jacksonville, librarian (re-elected), and Dr. J. Harris Pierpont, Pensacola, delegate to the American Medical Association.

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The Kentucky State Association of Railway Surgeons will hold the 4th Annual meeting in Louisville, Ky., on May 12th and 13th, 1908.

The L. and N. R. R., and other lines reaching Louisville, will give passes upon request of their respective local surgeons.

### MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

The thirty-fourth annual meeting of the Mississippi Valley Medical Association will be held in Louisville, Ky., October 13, 14, 15, 1908, under the presidency of Dr. Arthur R. Elliott, of Chicago.

Announcement has just been made of the selection of the orators for the coming meeting, by the President. The Address in Medicine will be delivered by Dr. George Dock, Professor of Medicine in the University of Michigan, Ann Arbor; and the Address in Surgery by Dr. Arthur Dean Bevan, Professor of Surgery in Rush Medical College, Chicago. The mere mention of these names is enough of a warrant that this feature of the program will be in every way first-class.

The local Committee of Arrangements in Louisville has selected The Seelbach hotel as headquarters, the general sessions and the section meetings being held in the hotel's large auditoriums.

One of the features of the entertainment projected is a smoker in the famous Rathskeller of the hotel—the finest of its kind.

The McDowell button, so much admired at the 1897 meeting in Louisville, will be reproduced in bronce for this meeting.

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### THE MEDICAL ASSOCIATION OF GEORGIA.

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The Medical Association of Georgia held its Fifty-Ninth Annual Session at Fitzgerald, April 15, 16 and 17. Although the place of meeting was not in a central portion of the State, in spite of the inconvenient railroad schedule from many points, the attendance was very good, and the quality of the papers was excellent. The assembly hall was also well attended during the reading of all the papers—there being no social diversions to distract attention from the scientific part of the program.

Much credit is due Dr. M. A. Clark for the business-like manner in which the affairs of the Association were transacted.

WEDNESDAY, APRIL 15.

Morning Session, 9:30 O'clock.

Prayer—By the Rev. J. C. Flanders.

Address of Welcome in Behalf of the City—Mayor J. G. Knapp.

Address of Welcome in Behalf of the Local Profession—L. S. Osborne.

Response to Address of Welcome—R. B. Barron, Macon.

Report of the House of Delegates.

READING OF PAPERS.

10:30 to 1 O'clock.

I. A Resume of 148 Cases of Typhoid Fever with Reference to the Efficacy of Therapeutic Fasting.

R. M. Harbin, Rome.

ABSTRACT.—The food question is the most important. Toxemia is more marked when the gastro-intestinal symptoms are present. The exceptional cases require liberal feeding. The typhoid bacillus is found to originate chiefly in the intestinal canal and lymphopoietic system. The battle ground of treatment lies in the intestinal canal, for the nourishment should not be allowed to increase saprophytosis. Toxin is more dangerous to cell life than inanition. Organs furnishing avenues of infection should be kept passive. Typhoid toxin does not necessarily produce high temperature, and excessive nitrogenous waste probably results from mixed infections. Toxemia is a greater cause of emaciation than lack of food. Food management will protect a patient from the usual dangers. As sthenic cases furnish the more violent types, fasting is more admissible. Intestinal complications are as common in ambulatory cases as in others. Hemorrhage furnishes a greater danger by setting up conditions favorable to sepsis. Symptoms are no guide as to the presence of intestinal lesions, and routine feeding is more or less necessary. Tendencies to relapse are more frequently shown in abortive cases. Tympanites causes an increased area for absorption, and a food surplus increases peristalsis. Scientific data prove that clinical diagnosis may be relied upon with a reasonable degree of accuracy. Fasting favors the course of a normal typhoid infection, which is usually mild, and should be applied in severe cases only. Fasting enhances the effect of hydrotherapy. Gelatin lessens nitrogenous waste, and prevents hemorrhage. There was a mortality of 4.7 per cent.

2. Chills in Typhoid Fever—C. W. Strickler, Atlanta.
3. Advantages of Wiring Femur Over Other Methods, with Report of Cases—Craig Barrow, Savannah.
4. A Case of Superfetation—R. V. Martin, Savannah.
5. The Diagnosis and Treatment of Bright's Disease—H. F. Harris, Atlanta.
6. The Necessity for the Proper Care of School Children's Eyes—Dunbar Roy, Atlanta.
7. The Surgery of the Tubes and Ovaries—Geo. A. Wilcox, Augusta.
8. Creeping Eruption—G. O. Brinkley, Savannah.
9. The Results of Vaccine Therapy in Acute and Chronic Infections—J. Edgar Paullin, Atlanta.  
ABSTRACT.—Infections, acute and chronic, localized and general. Portal of entry. Methods employed by the body to resist the invasion of micro-organisms. Resistance. The presence in the body fluids of opsonin. The influence of opsonin on bacteria. Sensitized bacteria. Method of preparing vaccines and their standardisation. Trend of events happening on the injection of a vaccine. Relation of cases and results obtained by the use of vaccines. Conclusions.
10. A Plea for the More Frequent Use of Obstetric Forceps—J. H. McDuffie, Columbus.  
ABSTRACT.—Special reference to pathological conditions that may be avoided by not allowing "nature to take its course" in many cases. More harm results to mother and infant from prolonged and needless delay than is ever traceable to the use of forceps in skillful hands.
11. Puerperal Eclampsia and Its Treatment—Jno. W. Daniel, Savannah.
12. Cholelithiasis—Willis Jones, Atlanta.
13. Early Operation as a Means of Preventing Complications and Reducing the Mortality in Appendicitis—J. L. Campbell, Atlanta.  
ABSTRACT.—If all cases of appendicitis were operated upon during the first twenty-four or thirty-six hours the mortality

would be almost nothing. Remarks on early papers and discussions before the Medical Association of Georgia. Statistics from Georgia hospitals and sanitariums. Report of some acute cases, and cases of abscess with drainage.

#### AFTERNOON SESSION.

2:30 to 5:30 O'clock.

14. Cause of Scrotal Hematocele.

ABSTRACT.—Etiology, symptoms, and diagnosis. Report of a case.

15. Report of a Case of Ingestion of Safety Pin by a Child Two Years of Age—Subsequent Passage by Bowel Without Symptoms—Whatley W. Battery, Jr., Augusta.

ABSTRACT.—Comments on quick passage of pin into bowel, as illustrated by skiagraph taken three hours after ingestion. Absence of pain in abdomen during passage. Treatment.

16. Hydrocele and Spermatocoele, with Report of Cases—W. L. Champion, Atlanta.

ABSTRACT.—Varieties, cause, diagnosis, frequently confused with other diseased conditions; the frequency of syphilitic involvement of the testicle as a cause of hydrocele. Carbolic injections, and when they should be used.

17. Early Operation for Adenoids—A. W. Stirling, Atlanta.

ABSTRACT.—Besides the "stomach attacks," disturbed sleep, aphosia, earache, perforation of the tympanic membrane, deafness, mastoiditis and diminished power of resistance which may follow upon adenoids, a continuation of mouth breathing from nasal obstruction is likely in early life, and especially at the time of the second dentition, to produce permanent deformities. The palate is narrowed and elevated through compression of the upper jaw unopposed by the tongue, which plays an important part in normal conditions; the nasal septum is consequently bent; the nostrils are narrowed and immobile; the teeth are crowded; and pigeon-breast also results.

18. Colic, its significance—T. J. Charlton, Savannah.

ABSTRACT.—Colic is a disorder first met with in the newborn baby, occurs during all stages of life and is by no means uncommon in old age. Thus frequently met it becomes commonplace and like all things commonplace is more or less neglected. Colic on the other hand is often a marked and early symptom of serious and often fatal abdominal disease. The

physician should constantly bear this in mind and before assuming that colic is merely the result of a minor disorder of digestion should first convince himself by exclusion that it is not the beginning of serious abdominal disease.

19. Respiratory Expansion—A Hitherto Neglected Factor in the Treatment of Pott's Disease—Michael Hoke, Atlanta.

ABSTRACT.—Attention is called to the necessity of permitting the chest to expand and develop while the patient is wearing a jacket for immobilizing the spine, and methods are shown how this may be done.

20. Mucus-Colitis and its Treatment—J. L. Farmer, Savannah.

21. Gonorrhœa—Thos. Chason, Donaldsonville.

22. A Favorable Report on the Use of Gonococcic Vaccine—E. G. Ballenger, Atlanta.

ABSTRACT.—During the past six months the author has been greatly impressed by the success he has been able to attain in the treatment of gonorrhœal conditions by injections of gonococcic "vaccine" or "bacterin," and embodies in this paper certain facts concerning this form of therapy and his impressions regarding its use. The clinical symptoms have been relied upon in selecting the time at which injections should be administered, and are believed to be of as much value in gonorrhœa as the "opsonic index." Of much importance is the treatment of all conditions and complications, so as to procure a free flow of fluids through the injected foci, so as to bring the juices laden with opsonins to the points where they are most needed.

23. The Practical Value of Cystoscopy, Ureteral Catheterization—Jabez Jones, Savannah.

24. Treatment of Epilepsy—Wesley Taylor, Atlanta.

ABSTRACT.—Care of general health necessary for the treatment of nearly all chronic diseases, and especially out of door exercise as shown in institutions where the patients are employed outside. The patients have fewer attacks when the weather permits them to do even hard manual labor and more attacks on Sunday than on week days. Principles on which bromide acts. Common salt, which is a nerve irritant, can be replaced in the human body by bromide, a nerve sedative, by proper dietary measures. Disadvantages to this method. Cases suitable to such treatment. Other methods of treatment. High blood

pressure in epileptics. Advantages directed toward the lowering of blood pressure.

25. Neurasthenia—W. Herbert-Adams, Savannah.

ABSTRACT.—Its increasing prevalency, and the reasons therefor. Many of the assigned causes are in reality effects of the diseases. Necessity, for clearing differentiating neurasthenia from hysteria, hypochondria, melancholia and the organic neuroses. Therapeutics, include rest-cure, electricity, hydrotherapy, drugs, and, most of all, psychotherapy. Reasons why the neurasthenic falls an easy prey to Christian Science, osteopathy, advertising quacks, and other medical charlatans. Thoroughly imbue patient with your ability to cure him, then study each case carefully and treat it intelligently or let it alone, remembering that each failure makes the case far less amenable to future treatment.

26. Report of Five Cases of Facial Neuralgia Treated by Injections of Osmic Acid—Chas. C. Harrold, Macon.

ABSTRACT.—Four of above cases were typical, two were fresh cases and two were very severe cases of long standing. In all four of these the nerves were injected at their exits through the foramina on the face, the supra-orbital, infra-orbital and the mental. In no case were all three injected and in no case was it thought necessary to expose the nerves as recommended by Murphy. In all four of the typical cases the relief was immediate, absolute and lasting for varying lengths of time.

NIGHT SESSION—WEDNESDAY.

7:30 to 10 O'clock.

27. Weaning—H. McHatton, Macon.

ABSTRACT.—Breast milk is the best food for the infant. Modified cow's milk is the best obtainable artificial food. No proprietary food on the market can be given alone and continuously to an infant with safety. Weaning should always be gradual. The most important thing to observe with a baby is to keep an absolute record of its weight. Lactation and pregnancy are not incompatible.

28. Fermented Milk (Kefir): Its Origin and Therapeutic Application—L. Amster, Atlanta.

ABSTRACT.—Food among the Asiatic people, adopted by the medical profession in Europe—its value recognized in the



United States. Chemical analysis. Therapeutic application in acute diseases, fevers, diseases of the stomach and intestines, rheumatoid arthritis, Bright's disease, diabetes, pulmonary diseases, etc. Contra-indications.

29. Prealbuminuric Retinitis, with Report of Two Cases—H. H. Martin, Savannah.

ABSTRACT.—The relation between arterial fibrosis and atheroma. The relation between each of these and the various forms of nephritis, and whether or not there is another form of arterial degeneration as yet unclassified: namely, a hyaline degeneration.

30. Intestinal Toxemia—A. B. Simmons, Savannah.

31. Elimination and Alteration—B. P. Oliveros, Savannah.

ABSTRACT.—A reference to elimination in disease, especially in general septic conditions, toxemias, and the pregnant state by the use of any measures pertaining thereto, with a special reference to diaphoretics, diuretics and evacuants—also showing the close relationship of alteration, whereby certain drugs exert alterative action on the circulation, performing a dual office of assisting elimination, or making that process unnecessary.

32. Purpura Fulminans—R. P. Izlar, Waycross.

ABSTRACT.—Definition. Etiology and nature. Micro-organisms in the development of purpuric conditions, generally infectious conditions. Report of cases. Classification and course of the disease. Scope of drugs. Exaggerated mental conditions. Unfavorable prognosis.

33. The Use and Abuse of Irrigations—Wm. Perrin Nicolson, Atlanta.

34. Delayed Toxic Effect of Chloroform Anæsthesia—J. M. Sigman, Savannah.

35. A Case of Supra-Pubic Lithotomy—The Technique of Supra-Pubic Cystotomy and the After-Treatment—Eugene R. Corson, Savannah.

ABSTRACT.—The removal of eight stones weighing seven ounces; four of these stones forming a cup in which the other stones were free to move. The technique of supra-pubic cystotomy with special reference to the control of hemorrhage, the incision into the bladder, and the subsequent drainage and after-treatment generally. The use of a long catheter perforated in

the middle which does the double duty of a catheter a temeure and supra-pubic drain. Paper illustrated by photograph of the stones and a figure showing the use of a combined catheter and supra-pubic drain.

36. Leucocytosis in Acute and Chronic Diseases—Walter S. Wilson, Savannah.

ABSTRACT.—Insufficiency in many cases of total count. The value of the differential count in diagnosis and prognosis to the surgeon and to the physician. Sources of error. Limitations. Interpretations must be made in the light of clinical conditions.

Exclusive Milk Diet for 12 Years—W. W. Terrell, Douglas.

#### THURSDAY, APRIL 16.

Morning Session, 9 to 1 O'clock.

President's Address.

Secretary's Report.

Report of House of Delegates.

#### READING OF PAPERS.

37. Long and His Discovery, with Comment on the Work Being done by the Federation of Women's Clubs for a Monument to His Memory—J. H. Goss, Athens.

ABSTRACT.—The above paper discusses the claim of Dr. Crawford W. Long, and recites the old story that he did the first operation in all the world under ether anesthesia. Makes a plea for the medical profession to join forces with the Federation of Women's Clubs and erect a monument to Long. This movement has already been inaugurated by the Athens Woman's Club.

38. Pneumonia—J. E. Sommerfield, Atlanta.

39. Lobar Pneumonia in Infants—Herman W. Hesse, Savannah.

40. The Indications for the Mastoid Operation—F. P. Calhoun, Atlanta.

ABSTRACT.—The relation that the mastoid bone bears to the intracranial structures is important for the general practitioner and surgeon to know, as well as the otologist. Permanent injuries to vital structures result from neglect. Usually the indications for the mastoid operations are evident, on account of pain, swelling, temperature, and aural discharge. Accurate his-

tory is first necessary. Inspection determining then if there is any swelling or redness over or about the mastoid. Furunculosis, or otitis externa, might cause this symptom. Swelling is the rule in children and infants, as it is an early sign; rare or a late symptom in adults. Palpation is the most valuable sign of mastoiditis; and it is the one sign for the general practitioner to make a diagnosis in the absence of other symptoms. The temperature is variable. Usually high in children; normal elevated one or two degrees in adults. The canal examination a method of examination more for the otologist than the practitioner; a bacteriological examination of the aural secretions is helpful. Blood examinations are of no practical value.

41. Antipyretics in Febrile Diseases—Jas. B. Baird, Atlanta.

42. Cicatricial Strictures of the Esophagus—Geo. R. White, Savannah.

ABSTRACT.—The difficulties met in the management of these cases are explained by a study of the pathology of the diseased organ. The high mortality is due to starvation and perforation of esophagus by bougies. Methods devised for the relief of this condition and the cause of failure of most of them. Inadvisability of attempting retrograde dilatation and esophagotomy. Kalder's gastrostomy recommended as a preliminary for nourishment and as an aid to treatment. A satisfactory method of dilation by the author's bougies making use of both the mouth and gastrostomy.

43. Hip Joint Operation, Formation of False Joint and Young Man Walking—J. T. Gammage, Pineview.

ABSTRACT.—Description of operation for tubercular hip, which produces such wonderful results in this case and previous cases.

44. Senile Changes in Bachelors—M. X. Corbin, Savannah.

45. Treatment of Fracture of the Clavicle—W. F. Westmoreland, Atlanta.

ABSTRACT.—The frequency of fracture of the clavicle. Difficulty of holding fractured ends in apposition, mechanical not muscular. Present methods usually unsatisfactory, and based upon erroneous conclusions. The essayist suggests plan based upon reduction by position and the application of permanent plaster of paris splints.

## 46. American Hookworm—A. G. Fort, Lumpkin.

ABSTRACT.—Deductions drawn from experience in treatment of 408 cases. Definition. History. Its prevalence in South-west Georgia. Description of parasite. Description of eggs. Infective stage. Two modes of infection. The larvae. Suitable conditions for development. Ground itch. Race. Sex. Symptoms. Relative number of parasites and length of time of infection. Clinical picture. Diagnosis. Treatment. Preparation of patient. Diet. Thymalsetanophthal. Number of treatments necessary. After treatment. Prophylaxis.

## 47. Practical Disinfection—C. J. Montgomery, Augusta.

ABSTRACT.—Meaning of common terms. Objects to be attained. Importance and limitation of physical agents. Chemical agents, liquid and gaseous; advantages and disadvantages of these commonly used. Hygienic management of infectious diseases. Disinfection of skin, feces, urine, sputum, etc. Treatment of crockery and silverware, bed-linen and clothing, books and furniture. Room disinfection.

## 48. Drainage in Suppurative Conditions About the Abdomen—W. S. Goldsmith, Atlanta.

## 49. The Personality of the Patient a Factor in Treatment—I. H. Adams, Macon.

ABSTRACT.—Medicine an art, as well as a science. Great advances in medicine have been along one line at a time. Therapeutics now in the ascendancy. In treatment, we consider the causes of disease, the remedies used to combat disease, and the patient's reaction to the disease and the remedies used. Best results attend the efforts of the physician who treats the patient and not the disease. Train the powers of observation and in due time deductions will be drawn automatically. Face, form, and manner, give inestimable evidence of vital resistance.

## AFTERNOON SESSION—THURSDAY.

2 to 6 O'clock.

## 50. Hereditary Multiple Osteomata—T. P. Waring and E. R. Corson, Savannah.

## 51. Some Remarks Concerning Deaf-Mutism—M. M. Stapler, Macon.

ABSTRACT.—Showing a probable cause of deaf-mutism due to closure of eustachian tubes, displacement of the stapes and exhaustion of the stapedius muscle and their correlation in producing the deafness. How to remove these causes and what

results their removal has shown. Why we have not established hearing heretofore for mutes. Preconceived opinions and inherited prejudice as a handicap to the advance of original, scientific work for deaf-mutes.

52. Headaches and Neuralgia Due to Diseases of the Nose and Accessory Sinuses—Hugh M. Lokey, Atlanta.

ABSTRACT.—Headaches and neuralgia are not diseases per se—but are symptoms of morbid conditions, either at the seat of pain or referred through nerve reflexes from distant sources. The anatomical closeness of the nose and accessory sinuses, with poor drainage facilities of the maxillary antra and the ethmoidal and sphenoidal cells, with the closely anastomosed nerve supply, predispose to nerve irritation and headaches from diseases of these parts. While a large per cent. of these cases are operative, and positive diagnosis is sometimes impossible, there are many cases that can be treated and relieved by one who is not a specialist in rhinology. But the lesion should be sought out and treated, and the physician should not be content in treating the symptoms.

53. Spongy Angiomata, Congenital or Acquired—M. B. Hutchins, Atlanta.

ABSTRACT.—Angioma spongiosum a better name than angioma cavernosum, because cavernous parts often constitute less than half the growth. Old methods of treatment, as electrolysis, cautery, coagulants, or ligature often fail. Clean dissection, plastic repair best, where area is not too great. Acquired or traumatic, spongy, vascular lesions a new and rather different type, but of sufficient likeness to be included in the discussion. Treatment of these minor surgical.

54. Operation for Retrodeviation of the Uterus—E. C. Davis, Atlanta.

ABSTRACT.—First: The normal supports of the uterus. Second: Some of the causes operative to cause displacements. Third: Various operations which have been performed to relieve retro-deviation; first the formation of adhesions or the fixation of the uterus; second, ventro-suspension of the uterus or formation of an adventitious ligament; third, operations upon the broad ligaments; fourth, operations upon the utero-sacral ligament; fifth, operations upon the verico-uterine ligament; sixth, operations upon the round ligaments, and these sub-divided as follows: First, plication of the round ligaments; second, Alexander's operation and its various modifications; third, Mayo's operation; fourth, Dudley's operation; fifth, Noble's operation and its various modifications.

55. Pelvic Inflammation—Etiology, Prevention and Treatment—R. R. Kime, Atlanta.

56. Gastro-Jejunostomy—Report of Cases—Edward G. Jones, Atlanta.

ABSTRACT.—

(a) For pyloric stenosis.

(b) For chronic gastric ulcer without stenosis.

(c) For duodenal stenosis.

No loop employed in any case.

Absence of vomiting, relief from pain, etc., after these operations.

57. Treatment of Alcoholism and Drug Habit—A. L. R. Avant, Savannah.

ABSTRACT.—Lack of literature on this important subject. Paper based on daily observations. Plain drunk needs very little attention. Physicians usually call after constant drinking spells, and find the patient suffering from gastric disturbances. Treatment consists in cleansing stomach, saline purge, systematic treatment, liquid diet, and treatment of nervous system. Delirium tremens demands more energetic and persistent efforts. In drug habitues we endeavor to build up patient and improve moral stamina. Gradual withdrawal of drugs in severe cases, substitute other remedies if necessary. Secure pleasant surroundings for patient. Secure co-operation of patient.

58. The State's Attitude to the Drug Habitue—J. L. Frazer, Fitzgerald.

59. Treatment of Sprains—Theodore Toepel, Atlanta.

ABSTRACT.—Sprains. Kinds. Ligaments and tissues involved. Sprains in subjects of rheumatic or gouty habit; in strumous subjects. Treatment of ordinary sprains. Application of hot air. Importance of massage in treatment. Encouragement of activity between treatments. When the appliance of plaster bandage becomes necessary. Massage and plaster cast. Resistive exercises. Chronic sprains. Atrophy of muscle and immobility. Improved treatment.

60. The Best Point to Open the Abdomen in Operation on the Vermiform Appendix—L. C. Fisher, Atlanta.

61. Sarcoma of the Omentum, with Report of an Interesting Case—J. R. Garner, Atlanta.

62. Presentation of a New Eye Dressing—J. Lawton Hiers, Savannah.

FRIDAY MORNING, APRIL, 17.

9 to 1 O'clock.

Report of House of Delegates.

READING OF PAPERS.

63. Milk: Its Relation to the Public—Ralph M. Thompson, Savannah.

64. Chloroform in Childbirth, and Some of the Accidents of Delivery—L. S. Osborne, Fitzgerald.

65. The Treatment of Crushes of the Extremities—Thos. H. Hancock, Atlanta.

ABSTRACT.—Shock caused from crushes; how to prevent it, and how to treat it. When to operate. How to amputate. How to feed these patients.

66. Anatomy of the Peritoneum and Gastro-Intestinal Tract from the Standpoint of Development—W. B. Armstrong, Atlanta.

67. A Successful Laminectomy, with Patient Present—Howard J. Williams, Macon.

68. Some remarks on Cholangitis—H. R. Donaldson, Atlanta.

69. Post-Operative Suppression of Urine—A. B. Cleborne, Savannah.

ABSTRACT.—The purpose of my paper is to show how little we know of (part 61, Suppression) pathologically and etiologically and to plead for more work to be done, in the dead-house and our experimental laboratories. Upon this we can only hope for a sound basis to write out our therapeutical ideas.

70. Indications and Technique of Infusion—Monroe Smith, Atlanta.

71. Suppuration of the Middle Ear—J. L. Jackson, Savannah.

72. Fractures of the Skull—W. A. Norton, Savannah.

**ABSTRACT.**—Description of extensive fractures of skull. Duret's principle. Contre-coup fracture of the base. Report of case of pressure on brain, causing interruption and suspension of thought. Report of case of great destruction of skull and brain tissue—complete recovery of mentality. Drainage from frontal sinus through nose. Summary.

73. Pyelitis in Pregnancy—F. G. Hodgson, Atlanta.

74. Our Duty to the Consumptive—L. C. Roughlin, Atlanta.

75. Meningitis—J. C. Luke, Ocilla.

76. Tumors of the Bladder—A. L. Fowler, Atlanta.

**ABSTRACT.**—Our knowledge of vesical tumors a recent acquisition. The cystoscope triumphant in the perfection of our diagnostic means. The grave danger when employed by the experienced. Some photographs.

77. Sacro-Iliac Disease—C. R. Andrews and Michael Hoke, Atlanta.

**ABSTRACT.**—The sacro-iliac synchondroses are true joints, capable of being affected as are other joints. Anatomic relations render these joints more liable to strain and displacement. Importance to the general practitioner, obstetrician and gynecologist. Toxic inflammation superimposed on chronic and acute conditions of the sacro-iliac joints.

78. Typhoid fever—E. J. Dorminy, Fitzgerald.

79. Two interesting cases of Mastoiditis—J. H. Crawford, Atlanta.

**ABSTRACT.**—First. Primary mastoiditis of traumatic origin. Rare occurrence of primary mastoiditis in comparison to secondary. Percentage of cases originating as primary condition. Report of case. Sight of injury. Symptoms, etc. Description of operation. Remarks on anatomical structure and relation of mastoid cells to the middle ear favoring extension of infection. statistical summaries.

Second. Case of mastoiditis occurring in babe eleven months old. Structure of process in infants. Report of case. Unusual development of mastoid cells. Operation.

80. Post-Graduate Study in Europe, with Reference to Eye, Ear, Nose and Throat—O. H. Johnson, Athens.



**ABSTRACT.**—General consideration. Advantages of European study. Where to go. Comparison of opportunities in different European medical centers. How long to stay. Living expenses. Cost of courses and tuition. Traveling expenses. Suggestions as to different routes by land and sea, and hints to the traveler.

81. Significance of Arterial Hypertension—Its Treatment—Ralston Lattimore, Savannah.

**ABSTRACT.**—

1. Arterial hypertension in arteriosclerosis.
2. Arterial hypertension in nephritis.
3. Arterial hypertension without nephritis.
4. Arterial hypertension of unknown origin.
5. Arterial hypertension as a compensatory manifestation.
6. Effects and danger of arterial hypertension.
7. Therapeutic indications.
  - (a) preventive treatment.
  - (b) Adjuvant treatment.
  - (c) Emergent treatment.

**AFTERNOON SESSION.**

3 O'clock.

Election of officers was as follows: President, Thomas D. Coleman, of Augusta; First Vice-President, W. B. Armstrong, Atlanta; Second Vice-President, Ralston Lattimore, Savannah; Secretary-Treasurer, Claude A. Smith, Atlanta; Delegates to the American Medical Association, Drs. H. F. Harris, Atlanta, and W. W. Owen, Savannah. The next meeting will be held in Macon.

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**NAMES AND ADDRESSES OF THE SECRETARIES OF  
THE VARIOUS STATE EXAMINING BOARDS.**

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Arizona, Dr. W. H. Sanders, Montgomery.  
Alabama, Dr. Ancil Martin, Phoenix.  
Arkansas (R), Dr. F. T. Murphy, Brinkley.  
(H) Dr. V. H. Hallman, Hot Springs.  
(E) Dr. A. J. Widener, Little Rock.  
California, Dr. Charles L. Tisdale, Alameda.

- Colorado, Dr. S. D. Van Meter, 1723 Tremont St., Denver.  
Connecticut (R), Dr. Chas. A. Tuttle, New Haven.  
    (H) Dr. E. C. M. Hall, 82 Grand Avenue, New Haven.  
    (E) Dr. T. S. Hodge, 16 Main Street, Torrington.  
Delaware, Dr. P. W. Tomlinson, Wilmington.  
District of Columbia, Dr. George C. Ober, Washington.  
Florida (R), Dr. J. D. Fernandez, Jacksonville.  
    (H) Dr. C. W. Johnson, Jacksonville.  
Georgia (R), Dr. E. R. Anthony, Griffin.  
    (H) Dr. R. E. Hinman, Atlanta.  
    (E) Dr. C. H. Field, Marietta.  
Hawaii, Dr. George Herbert, Ilakea St., Honolulu.  
Idaho, Dr. W. F. Howard, Pocatello.  
Illinois, Dr. J. A. Egan, Springfield.  
Indiana, Dr. W. T. Gott, 120 State House, Indianapolis.  
Indian Territory.  
    Central District, Dr. J. B. Smith, Durant.  
    Northern District, Dr. D. F. Fortner, Vinita.  
    Southern District, Dr. W. L. Peters, Chickasha.  
    Western District, Dr. M. L. Williams, Muskogee.  
Iowa, Dr. Louis A. Thomas, State House, Des Moines.  
Kansas, Dr. D. P. Cook, Clay Center.  
Kentucky, Dr. J. N. McCormack, Bowling Green.  
Louisiana (R), Dr. F. A. LaRue, 211 Camp Street, New Orleans.  
    (H) Dr. Gayle Aiken, New Orleans.  
Maine, Dr. Wm. J. Maybury, Saco.  
Maryland, (R), Dr. J. P. McP. Scott, Hagerstown.  
    (H) Dr. Jos. S. Garrison, 848 W. North Avenue, Baltimore, Md.  
Massachusetts, Dr. E. B. Harvey, State House, Boston.  
Michigan, Dr. B. D. Harrison, 205 Whitney Building, Detroit.  
Minnesota, Dr. W. H. Fullerton, St. Paul.  
Mississippi, Dr. J. F. Hunter, Jackson.  
Missouri, Dr. J. A. B. Adcock, Warrensburg.  
Montana, Dr. Wm. C. Riddell, Helena.  
Nebraska, Dr. E. J. C. Sward, Oakland.  
Nevada, Dr. S. L. Lee, Carson City.  
New Hampshire (Regent) H. C. Morrison, Concord.

- (R) Dr. J. T. Greeley, Nashua.  
 (H) Dr. R. V. Sweet, Rochester.  
 New Jersey, Dr. J. W. Bennett, Long Branch.  
 New Mexico, Dr. J. A. Massie, Santa Fe.  
 New York, (Laws), Dr. Howard J. Rogers, Albany.  
 (Examinations) Dr. C. F. Wheelock, Albany.  
 Dr. Maurice J. Lewi, 501 Fayette Park, New York City.  
 North Carolina, Dr. G. T. Sikes, Grissom.  
 North Dakota, Dr. H. M. Wheeler, Grand Forks.  
 Ohio, Dr. George E. Matson, Columbus.  
 Oklahoma, Dr. J. W. Baker, Enid.  
 Oregon, Dr. B. E. Miller, The Dekum, Portland.  
 Pennsylvania (Council), Dr. N. C. Shæffer, Harrisburg.  
 (R) Dr. Winters D. Hamacker, Meadville.  
 (H) Dr. Joseph C. Guernsey, Philadelphia.  
 (E) Dr. W. H. Blake, Philadelphia.  
 Philippine Islands, Dr. F. W. Dudley, Manili.  
 Porto Rico:  
 (Bd. of Health), Dr. Wm. F. Smith, San Juan.  
 (Bd. of Exam's.), Dr. Quevedo Baez, San Juan.  
 Rhode Island, Dr. Gardner T. Swarts, Providence.  
 South Carolina (R), Dr. W. M. Lester, Columbia.  
 South Dakota, Dr. H. E. McNutt, Aberdeen.  
 Tennessee, Dr. T. J. Happel, Trenton.  
 Texas, Dr. G. B. Foscue, Waco.  
 Utah, Dr. R. W. Fisher, Salt Lake City.  
 Vermont, Dr. W. Scott Nay, Underhill.  
 Virginia, Dr. R. S. Martin, Stuart.  
 Washington, Dr. C. W. Sharples, Seattle.  
 West Virginia, Dr. H. A. Barbee, Point Pleasant.  
 Wisconsin, Dr. J. V. Stevens, Jefferson.  
 Wyoming, Dr. S. B. Miller, Laramie.

—*St. Louis Medical Review*, March, 1908

#### FIFTH PAN-AMERICAN MEDICAL CONGRESS.

To the Medical Profession.

Gentlemen:

The government and the people of the Republic of Guatemala, as well as the National Committee of the Fifth Pan-Amer-

ican Medical Congress are actively endeavoring to do all in their power, in a sure and efficient way, to make this meeting a great success.

With this object in view the Committee will be pleased to invite you personally to attend, as well as the members of the Society or Medical Fraternity to which you belong, in order that through your presence and works the certain success of the Congress, that science expects of its representatives, will be assured.

The Committee hopes that you and the other members of your institutions will meet at Guatemala on the 5th, 6th, 7th, 8th, 9th and 10th of August, 1908, and sincerely begs that from now on you will not hesitate to keep yourself in fraternal relations with this Committee, and also that you will let us know beforehand if you intend to attend the Congress in person or to send some scientific contributions.

The Committee hopes to receive a reply shortly to the invitation to this meeting, which should serve as an incentive to unite professional interests, to stimulate the advance of medical science and to contribute to the preservation of the health and the prolongation of the life of the people of the Americas.

We take advantage of this opportunity to express to you the best regards of,

Yours very truly,  
Juan J. Orteaga, Pres.  
Jose Azurdia, Sec'y.

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#### NOTICE TO ALUMNI OF THE TULANE MEDICAL DEPARTMENT

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It is important that all graduates of Tulane intending to be present at the meeting of the A. M. A. in Chicago, June 2nd to 5th, should write at once to Dr. Hugh B. Williams, No. 100 State street, for information concerning the gathering of the Alumni on June 2nd. Tulane headquarters will be at the Auditorium Hotel and Alumni are urged to call, upon their arrival, for information. This is important.

The American Medical Editor's Association will convene in its thirty-ninth annual session in Chicago, May 30th and June 1st, in the Auditorium hotel.

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The annual meeting of the Medical Society of the State of California was held at Coronado, April 21st to 23rd, inclusive.

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The Thirty-fourth Annual Report of the Cincinnati Sanatorium, for the year ending November 30th, 1907, is received from Dr. Frank W. Langdon, the Medical Director. The year has been a successful one with 208 patients, 123 males and 85 females, 20 of whom were from Indiana, making 413 from our State since the beginning.

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The Charlotte Medical Journal and the Carolina Medical Journal have been consolidated, and will be published hereafter as the *Charlotte Medical Journal*. The editorial and business management will remain under the direction of Dr. E. C. Register, who has heretofore conducted the Charlotte Medical Journal.

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“Bone cases” should not be dressed too often after operation. The fine granulations which form are very liable to be pulled off with the removal of the packing.—*American Journal of Surgery*.

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REGULAR MEETING, FULTON COUNTY MEDICAL SOCIETY, APRIL 2, 1908.

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EDITED BY R. R. DALY, M. D.

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Dr. Hutchins presented a case of extra shrdlueta and in-

nocent syphilitic infection. The chancre was in the face. It gave history of cutting when shaving. Diagnosis had been confirmed as far as possible by microscopic examination, though, as Dr. Ballenger said, the *sperochetae pallida* was hard to find because of the difficulty in getting a proper smear until sealed dressing gave sufficient retained secretion.

Dr. P. Calhoun gave an interesting and comprehensive paper upon "A Synopsis of Personal Observation in 271 Mastoid Operations." (Published in full in our last issue.)

Dr. Toepel read a paper on "Sprains," which was well received.

Discussed by Dr. Hoke, Dr. Goldsmith, Dr. Hancock and Dr. Ogglesby.

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#### FULTON COUNTY MEDICAL SOCIETY, MARCH 19.

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Dr. Armstrong exhibited a case of bilateral malignant growth of breasts of female.

Dr. Hutchins said he had never seen a case so extensive as this one. There was some history of cancer in the family, but it was also possible that the etiology lay in specific gummata.

Dr. Hutchins re-exhibited his case of extra genital syphilitic infection. The original lesion is breaking down somewhat. Macular eruption has appeared and there is a fine, milliary, papular condition added. There is no gland involvement as yet.

Dr. J. E. Paulin read an excellent paper upon "The Opsonic Contents of the Body Fluids." Published in our last issue.

Discussed by Dr. McCrea, Dr. Andrews, Dr. Hutchins and Dr. Armstrong.

Dr. W. B. Armstrong gave an illustrating "Demonstration of the Anatomy of the Peritoneum and the Gastro Intestinal Tract," having special relation to the anomalies of position of the appendix. It was favorably discussed by Dr. McCrea, Dr. J. L. Campbell, Dr. Strickler, Dr. Kime and Dr. Clark.

## BOOK REVIEWS

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**THE CARE OF THE BABY.** By J. P. Crozier Griffith, M. D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania. Fourth Revised Edition. 12mo of 455 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$1.50 net.

In this work, the author has endeavored to furnish a reliable guide for mothers anxious to inform themselves with regard to the best way of caring for their children in sickness and in health. He has made his statements plain and easily understood, in the hope that the volume may be of service not only to mothers and nurses, but also to medical students and to practitioners whose opportunities for observing children have been limited. The first chapter of the book discusses the hygiene of pregnancy, the method of calculating the date of confinement, and similar data. There are chapters on bathing, dressing, and feeding, on the hours for sleeping, and on physical and mental exercise and training.

A new fourth edition of this work has just been issued, bringing it right up to date. In it many additions and corrections have been made, and a large number of illustrations added. A second appendix has also been added, giving full information regarding the infants diet in health and disease, as well as some formulae.

We commend the work as a reliable and satisfactory guide for women and nurses.

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**DIAGNOSIS OF DISEASES OF CHILDREN.** By LeGrand Kerr, M. D., Professor of Diseases of Children at the Brooklyn Postgraduate Medical School. Octavo of 542 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$5.00 net; Half Morocco, \$6.50 net.

Dr. Kerr's work differs from all others on the diagnosis of diseases of children in that the objective symptoms are particularly emphasized. The author believes that as the objective symptoms

are the main sources of information in diagnosing children's diseases the subject should be discussed with these symptoms as the foundation. The work is extremely practical, being written to help those who are engaged in the general practice of medicine to an early recognition of disease when it occurs in a child. The constant aim throughout has been to render a correct diagnosis as early in the course of the disease as possible, and for this reason differential diagnosis is presented from the very earliest symptoms. Just sufficient of etiology and pathology has been introduced to assist in arriving at right conclusions; and the sequelæ of the various diseases have been considered only to the extent that they may be anticipated and early recognized. The many original illustrations are of a higher order both from a practical and an artistic point of view. The physician will find these pictures a source of much information and help in his daily pediatric work.

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THE TECHNIC OF OPERATIONS UPON THE INTESTINES AND STOMACH. By Alfred H. Gould, M. D., of Boston, Massachusetts. Octavo volume, containing 190 beautiful original illustrations, some of them in colors. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$5.00 net; Half Morocco, \$6.00 net.

Dr. Gould's book is the direct result of the experimental study of gastro-intestinal technic, the operations having been first tried upon animals and then, in order to make the necesasry anatomic corrections, upon the cadaver. His idea is a new one, and will doubtless meet with immediate success. The object of the experiments was to simplify, where possible, the best gastro-intestinal operations, and the various steps and methods are shown by illustrations so clear, so anatomically accurate, and so pre-eminently practicable that but little text has been required. In fact, this was Dr. Gould's aim throughout: to present the technic of the standard operations upon the intestines and stomach by pictures alone, employing descriptive text only when it was impossible to express the idea pictorially. As the success of gastro-intestinal surgery depends upon an accurate knowledge of the elementary steps, a thorough account of repair is included, followed by a full description of all the important stitches, knots, and instruments used in intestinal surgery. The more important



subjects treated are: the repair of intestinal wounds, including the structure of the intestines and the stomach, and experimental research on repair; suture materials, needles, tying knots, sutures, and clamps; the anatomy of the intestines, including intestinal localization; operations upon the intestines, operations upon the stomach. The beautiful illustrations, one hundred and ninety in number, are all original, and were made under Dr. Gould's direct supervision from actual operations.

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### A PRACTICAL GUIDE TO THE EXAMINATION OF THE EAR.

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BY SELDEN SPENCER, A. B., M. D., Instructor of Otology in Washington University, Aural Surgeon to Martha Parson's Free Hospital for Children. C. V. Mosby Medical Book and Publishing Company, St. Louis, Mo.

This little book is intended as a guide to undergraduate students in the course of Otology and as such well fills the aim of the author. Diagnosis is the fundamental part of any branch of medicine and many practitioners will be enabled, after a careful study of this brief work, to carry out their plan of diagnosis in a more systematic and intelligent manner.

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### NERVOUS AND MENTAL DISEASES. FOR STUDENTS AND PRACTITIONERS.

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BY CHARLES S. POTTS, M. D.

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Professor of Neurology in the Medical-Chirurgical College of Philadelphia. New (second) edition, thoroughly revised and greatly enlarged. In one 12mo. volume of 570 pages, with 133 engravings and 9 full-page plates. Price, cloth, \$2.50 net. Lea & Febiger, Publishers, Philadelphia and New York.

The handling of nervous and mental diseases in a single volume offers manifest advantages to practitioners and students

who wish a good grounding in two important subjects which have an obvious relationship. That Dr. Potts has accomplished this acceptably is indicated by the demand for repeated printings of his first edition, and now by the call for a revision. His book has always been noted for its clearness and evenness, the inclusion of everything to be expected in a manual, and the omission of recondite matters, which find their proper place in the large special works or in monographs. Dr. Potts carries his reader as far as most will care to go, qualifying him for examination or general practice on both subjects, and for their further pursuit in case he wishes to specialize. He has brought this new edition thoroughly abreast of the present day, incorporating all important advances and making many additions. The section on Mental Diseases has been completely rewritten to represent the radical change in the whole point of view from which this field is now regarded. As the book has grown larger by about one hundred pages in spite of condensation wherever possible, it may be said that the amount of information it contains has been increased in greater ratio than its pages, and the same is true of the illustrations. A number of colored plates have been introduced. In its new edition the book goes forward to fresh usefulness.

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### PRACTICAL FEVER NURSING.

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BY EDWARD C. REGISTER, M. D.

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Professor of the Practice of Medicine in the North Carolina Medical College. Octavo volume of 352 pages, illustrated. Philadelphia and London: W. B. Saunders Company, Cloth, \$2.50 net.

W. B. SAUNDERS COMPANY, Philadelphia and London.

This work completely covers the field of practical fever nursing. A nurse, before she can intelligently care for a fever patient, and anticipate all that is required of her by the physician, must have some knowledge of the disease and its medical treatment, some realization of the cause and significance of the signs and symptoms. Dr. Register, therefore, has described, in as non-technical a manner as possible, the pathology of the different

fevers, their prognosis, and the various methods of treatment. The work is thoroughly practical and nurses will find it the *most valuable book on nursing yet published*. The illustrations show the nurse how to perform those measures that come within her province; such as bathing, hypodermoclysis, administration of antitoxin, pulse and temperature taking, etc.

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### A MANUAL OF NORMAL HISTOLOGY AND ORGANOGRAPHY.

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BY CHARLES HILL, PH. D., M. D.

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Assistant Professor of History and Embryology, Northwestern University Medical School, Chicago. 12mo. volume of 463 pages, with 312 illustrations. Philadelphia and London: W. B. Saunders Company, 1906. Flexible leather, \$2.00 net.

Dr. Hill's fifteen years' experience as a teacher of histology has enabled him to present a work characterized by clearness and brevity of style and a completeness of discussion rarely met in a book of its pretensions. Particular consideration is given the *mouth and teeth*. The subject of Organography is also included.

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### MEDICAL GYNECOLOGY.

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BY HOWARD A KELLY, A. B., M. D., L. L. D., T. R. C. S. (HON. EDINB.)

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Professor Gynecological Surgery in the Johns Hopkins University and Gynecologist to the Johns Hopkins Hospital, etc. D. Appleton and Company, New York.

Dr. Kelly, with the assistance of a corps of able collaborators presents in a concise and interesting form the subject of Gynecology as it has evolved from its beginning as a minor specialty to its present dignity as a major surgical specialty.

Especial stress is justly placed upon the question of hygiene and prophylaxis which is one of the fundamental problems too

frequently neglected. Drs. Lillian Welch and Mary Sherwood have written the chapter on the hygiene of growing girls. Dr. L. F. Barker is responsible for the chapter on neurasthenia, hysteria, and psychasthenia. This chapter is said to contain the first explicit and detailed statement made by Dr. Barker dealing with this class of patients. Other subjects are written by such men as Prince A. Morrow, E. J. Ill, T. R. Brown, and a number of others.

Two features make it of particular value to the medical student, first its concise form, second its "up-to-date" character.

The book is well bound, contains excellent illustrations, and is one we can heartily commend as a work of great value.

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#### SAUNDERS' FORTHCOMING BOOKS.

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MESSRS. W. B. SAUNDERS COMPANY, medical publishers of Philadelphia and London, announce for publication before June 30th a list of books of unusual interest to the profession. We especially call the attention of our readers to the following:

Bandler's Medical Cynecology—Treating exclusively of the medical side of this subject.

Bonney's Tuberculosis.

Volume II, Kelly and Noble's Gynecology and Abdominal Surgery.

Volume IV, Keen's Surgery.

Grant's Constipation and Intestinal Obstruction.

Schamberg's Diseases of the Skin and the Eruptive Fevers.

John C. DaCosta, Jr.,'s Physical Diagnosis.

Todd's Clinical Diagnosis.

Camac's Epoch-Making Contributions in Medicine and Surgery.

All these works will be profusely illustrated with original pictures.

## SELECTIONS AND ABSTRACTS

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### DOCTOR AND DRIVER.

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The *British Medical Journal* relates the following story: Dr. ———, of Baltimore, was awakened one stormy night recently by a man who declared the doctor's services were wanted three miles out in the country. Just before the doctor called up the stable for his horse, the visitor asked what the charge would be. "Three dollars," was the reply. When the house containing the supposed patient was reached the man alighted first, and handing the doctor three dollars, remarked: "You needn't come in doctor. You see it is this way: No hackman would drive me out for less than six dollars, and it occurred to me that your horse might need exercise." The tale has more than one bitter moral. The doctor is expected to be at the beck and call of every one at any hour of the day or night; he is also expected to accept a fee which an ordinary workman would decline without thanks; and the worst of it is, the doctor so often does what is expected of him.—*Transvaal*.

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### NEW LAW FOR GERMANY.

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#### SUPPLEMENTARY MEDICAL PRACTICE ACT PROPOSED.

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The German medical journals contain the text of a bill now before the Reichstag which provides for the regulation of the practice of medicine by irregulars. This bill, which has caused considerable editorial comment, provides for the regulation of a large class of irregular practitioners, who are patronized by the public, but who are not qualified as physicians. The editorials admit that the bill is not perfect, but urge the medical profession to work for its enactment, as it is a step in the right direction and

a gain over present conditions, especially so far as public health is concerned.

The bill provides that every person who makes a practice of treating disease or morbid conditions of any kind, and who is not a legally qualified physician, must register his name and address with the police, record removals from time to time and keep a set of books open to the inspection of the police at all times. Persons known to have been convicted of crime or those whose methods are liable to injure the health of man or animals are not to be allowed to register or practice. Persons registering under this law are not to be allowed to treat venereal diseases. Public advertisement for remedies for such diseases as well as advertisement of aphrodisiac remedies for "loss of vigor," measures to prevent conception or to interrupt pregnancy, is entirely prohibited. The exploitation of any remedy liable to injure the health or to defraud the purchaser can be prohibited by a committee of the bundesrath. Advertisement of remedies, the composition of which or the essential factors in the manufacture of which are secret, is also forbidden. Practitioners registering under this law are forbidden to use any treatment not based on personal examination. This will preclude the use of "absent treatment." They are not allowed to use any narcotics except local anesthetics, neither are they permitted to use hypnosis or "mystic processes" in their treatment.

A commission formed by the Imperial Health Office is to be established by the bundesrath for the purpose of passing on remedies or substances claimed to be serviceable for the treatment of diseases of man or animals. This commission is to consist of a judge and of experts from the professions of medicine, veterinary science and pharmacy. Appointment is for five years. Making claims by advertisements or otherwise of properties possessed by remedies not borne out by the findings of the commission is punishable by imprisonment, fine, or both. The same penalty is to be applied to those making knowingly untrue statements with reference to the person of the manufacturer or originator, or to the person or persons responsible for the publication of the advertisement. Fine and imprisonment are also imposed on proof of the following: Soliciting for absent treatment by public announcement or advertisements; publicly announcing remedies for the prevention or cure of venereal diseases; publicly

announcing or recommending remedies for the treatment of disease of animals or man in which the constituents or essential character of the cure, or the process of preparation is kept secret or is obscured.

The *Munchener medizinische Wochenschrift* says editorially: "The bill does not in any sense fulfil the wishes of those physicians who seek the abolition of quackery. It contains, however, a number of practical measures for the restriction of quackery so that the removal of the worst outgrowths of this injury to the public health may be hoped for. Registration and the necessity of keeping books open to the inspection of the police will be a decided hindrance to the business of the quack. The other provisions of the bill contain much that is good. It should be the business of the physician to recognize in the bill what is positively offers rather than to complain about what is lacking, since a vigorous opposition is to be expected from those interested in the defeat of the bill."

The measure outlined above is of importance, since it introduces a new principle in medical legislation, namely, the regulation of irregulars, quacks and fakers by the local police rather than by the state. These people are granted the right to practice under police surveillance. All efforts made in this country so far have been for the prevention of the practice of medicine by anyone except those legally qualified to do so. When a sect or cult became so powerful that it could not be prevented from practicing, the difficulty has been met by admitting representatives of the sect and according them to the legal standing of physicians, regardless of their scientific standing. Recent legislation along osteopathic lines in a number of states is an example. The proposed German law attempts to meet the difficulty by allowing the followers of those fads and cults which a portion of the public wish to patronize to carry on their business, but under police surveillance and without at the same time lowering the standing and personnel of the recognized medical profession. This plan is worthy of careful study. The progress of the bill **and the practical results of the law, if adopted, will be watched with interest.**—*Journal Medical Economics*, April 11, 1908.

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## MEDICAL ORGANIZATION.\*

BY M. A. CLARK, M. D., MACON, GA.

"One of Matthew Arnold's clear thinking Yankees has said with epigrammatic brevity, that whenever three Americans get together, they organize." It is evident that he did not refer to the medical profession.

According to the earliest records, the first association of physicians into a medical society was in Boston in 1735. A report of an operation for stone in the bladder on a boy of six years was made to this society in November, 1741. There is no further record of its existence. The Philadelphia Medical Society was organized in 1765 but enjoyed only a short life.

The oldest medical society existing at the present day was.

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\*Read before the Georgia Medical Association, Fitzgerald, April 15-16-17, 1908.



founded in June 1766 with a membership of sixteen. I refer to the New Jersey Medical Society. Fifteen years later the Massachusetts Medical Society was organized with a membership of thirty.

The first medical organization in the South was in South Carolina, but so far as we can ascertain, it was of short duration. The first permanent society was the Georgia Medical Society in 1804 at Savannah. This society still exists and is one of our best organizations.

Except the Maryland Medical Society, the first state organization in the South was effected in 1846 under the title of the Medical Association of Alabama. This association was reorganized in 1873 so that it should consist of component county societies, but the last county was not organized into a society until 1888. This is the most complete and most powerful medical organization in America, and I do not think that I would exaggerate to say in the world. Fully 92 per cent. of the physicians of the state belong to the society, and through its committees it controls both the Boards of Medical Examiners and of Health, and the county societies are the county boards of health. This is a most striking example of what may be accomplished by the united and persistent efforts of a faithful few.

Packard in his History of Medicine in the United States, says that our own Crawford W. Long presented a full report of his first use of ether as an anesthetic in surgical operations to the Georgia State Medical Society in 1842, but we are unable to find any other reference to such an organization. Our Association was founded in 1849 under the name it now bears, the Medical Association of Georgia, and, as you already know, it was reorganized in 1905.

Under the original plan of organization any reputable physician of the State, when vouched for by two members of the Association and approved by the Board of Censors, became a member of the Association and attended or took part in it as he felt inclined. From year to year, we were able with no little effort to get about enough new members to equal the number of delinquents. Hence, the membership did not increase nor did the interest in the work grow to any extent. At the time of the re-organization in 1905, the total membership was six hun-

dred and twenty-five and there were neither county nor district societies.

The present plan of organization provides that the State Association shall consist of component county societies and the door of entrance must be the county society. In other words the Medical Association of Georgia is an aggregation of county societies and depends wholly upon these societies for its existence. This is a wise provision for there are in every locality matters of interest and importance to the profession of that vicinity which can not be properly dealt with by the State organization meeting annually, but must needs be left to the management of the County society. However, the State society can aid local societies by devising plans and helping them to execute these plans.

The existing plan provides for two bodies, a Legislative and a Scientific. The Legislative body is the business branch of the Association and is composed of delegates from each county society, every society being entitled to at least one delegate, and those having a membership of more than fifty, being allowed a representative for each fifty or fraction thereof. This constitutes the House of Delegates and meets on the afternoon before the Scientific Session sometimes called the General Session. All business and matters pertaining to the good of the profession and the public generally are considered in this body. That we may be democratic in the full sense, the deliberations of this session are submitted to the General Session for its approval. Also, the several delegates on their return to their respective societies should make a complete report of these meetings, that all may feel that they are an integral part of the Association and that it is as much theirs as if they had taken part in the proceedings.

The Scientific or General Session is composed of all members of the county societies in attendance and devotes the three days in session to reading and discussing scientific subjects. Being relieved of the business part of the Association, much more attention is given to the consideration of scientific topics. The short time this plan has been tried fully convinces us of the wisdom of its adoption.

Now, gentlemen, let me remind you, and I beg to make it emphatic, that the county society is the corner stone, the pillars,

the whole foundation, yes, the frame work, top, bottom, every part of the Association, and without the county societies there can be no State Association. Whatever affects one affects the other, useless each without the other. I have frequently heard some of the physicians especially of the smaller towns and villages, say that it is well to have a State Society but it is simply impossible to have a county society. We must rid ourselves of this erroneous notion before we can have our organization complete. Just as the brain is composed of multitudinous little cells so arranged that they work in unity, each depending upon and helping the other, and the aggregate of all their work constituting the thought, the will, the mind of the individual; so must the medical men of Georgia make up the working element of our Association, and all dependent upon each other must be so organized that the very best effort of every member is in harmony with that of the other and all together creating the great whole, our beloved Association.

In order that these county societies may be organized and encouraged to live and thrive, it has been deemed wise to have some one whose duty it is to visit them from time to time, at least once yearly, and renew their interest and foster their growth. After mature deliberation, it was thought best to have a representative from each Congressional district to look after the welfare of the counties in his respective district, and the Council was created, consisting of eleven members. They also constitute the Board of Censors and Finance Committee of the Association and are members of the House of Delegates.

The duties of the Councilors are by no means easy. To faithfully fulfill these duties, one must be wise, prudent, tactful, energetic, and ready and willing to make any sacrifice for the good of the profession. It requires a vast deal of thought and study and no little financial loss on account of absence from the duties of home, but the results, the benefits, to the profession and ultimately to humanity, more than repay the true, big-hearted, broad-minded, soul-loving physician. Gentlemen, in choosing your Councilors, you should at all times select the very best men in the Society, those most adapted to the work as well as willing to devote the time and energy to it. Every one, who takes up the work of organizer and does that work well, becomes a better, broader, and more useful man, for he can not organize others

without first becoming fully acquainted with and mastering self. No member of this Association should allow himself to seek this high office nor should he ever accept it solely for his own personal aggrandizement.

Fellow members of the Medical Association of Georgia, let me urge you to always select for your Council as well as your other officers the men most adapted to the place and to never allow yourselves to be controlled by personal or selfish motives.

It has been no easy task to organize the county societies we now have, and as has already been said, it is even more arduous to keep them organized and to get them to act. Allow me to recall to you a few of the difficulties as they appeared to me as one of your organizers.

The greatest obstacle to successful organization and the one most difficult to overcome is the petty jealousies among our physicians. How sad but true! Now frequently we find two good men of the profession so jealous of each other that they do not speak to the other in passing but rarely allow an opportunity to pass without saying some little mean thing about the other in the presence of the laity. Some live long and fairly useful lives and die without any fraternal feeling toward their fellow laborers. By thus acting they have made their duties more onerous and have degraded their high calling.

If you please, go to any village or town of the State where there has been no medical society and ask a physician about one of the lawyers or any other layman, and he will gladly recall his virtues and oftentimes magnify them. Now, ask him of his fellow physician and he will either condemn him outright or worse still "damn with faint praise." Is it not strange, passing strange, that such noble, charitable, self-sacrificing men should be so thoughtless of each other and so regardless of the other's welfare? There is not a grander, bigger-hearted, more charitable body of men than the medical men of Georgia, yet how prone at all times to speak slightly of each other and to make insinuating remarks about their brethren, thereby bringing the entire profession into disrepute. We can never command the respect due us by the public so long as we allow this grave fault to be so conspicuous.

Go to the legal fraternity and learn of them, thou medical man! Lawyers often abuse each other in the court room, the

one vying with the other in the use of scathing epithets. After the adjournment of court, they go out together laughing and jesting as if nothing unpleasant had occurred. Let a doctor make a slighting remark of another in that august presence and they are henceforth enemies and peradventure may attempt to outdo the notorious representative of pugilistic days. How the laity smile and the tongues of the gossipers wag, and still the doctors go on thus forever.

Now, wherein lies the difference? The lawyer is no better than the doctor. I do not think he is as good. It is because the legal profession are thrown constantly together and are enabled thereby to become well acquainted with their fellows, and there arises a bond of sympathy for each other as a result of this association.

The physician after receiving that priceless piece of sheep skin, alias parchment paper, chooses a location to practice his profession. He is young, hopeful, self-confident, and otherwise proud of self, but distressingly ignorant of the courtesy due from one physician to another, not having been taught on this important subject. Often he has never heard of the Code of Ethics much less learned of its teachings. It is truly the formative period of his professional career, and how he is received by his professional brethren and treated by them, makes or mars a useful life. How often have you heard it said that the old doctor has no sympathy nor respect for the young disciple of Aesculapius; and when we recall some remarks that have emanated from some good old nestors of the profession, we are forced to admit that this must be true. It is no wonder that so many of us draw ourselves up into our little shells and keep so inactive that we are weighted down with the moss of jealousy and hatred and are soured from the lack of communion with our fellows. Too well do I remember the reception accorded me when I first located in a little village of Georgia, and I shudder when I think of the influence it came so near having over me. Fortunately, I began early to attend the Association and was there directed in the proper way and encouraged to cultivate the true professional spirit.

Let me beg you of mature years and of much experience in the vicissitudes of life to extend a helping hand, speak an encouraging word, give a friendly nod in passing, to the young

doctor in your midst and above all to refrain from saying anything that will reflect upon him in any way. In helping our younger brethren to get the true conception of the physicians life, we not only help them to success and hapiness but we also benefit our fellows, and incidentally we cause many rays of sunshine to enter into the dark niches of our own lives.

Brethren, when we have freed ourselves from these petty jealousies and despicable bickerings and dwell together in peace and harmony, we will receive the respect and love due our noble calling but so sadly lacking now.

Another drawback to successful organization is procrastination, the sugar coating for laziness. Write to the average doctor to suggest a time to meet, to consider the work of organizing, and where is the answer? The echo answers where but the doctor never. He intends to write but was so busy. If by chance you get his attention long enough to organize, that is the last of it. He really expected to attend the meeting but was busy. We so often delude ourselves with the idea that we are too busy but, if we will only make a beginning, we will be surprised to find that it is so easy to become a constant attendant of these meetings.

These obstacles can be overcome only by having active county societies bringing the members into close and frequent association with each other.

Herbert Spencer has said: "Socially as well as individually, organization is indispensable to growth; beyond a certain point there can not be further growths without further organization." This is equally as applicable to medical men. The county organization means growth of the profession in that county. The convening from time to time and discussing the many phases of our science, the interchange of original ideas, and the relation of personal experience, tend to incite within us new life and greater desires to know more and to do better work. If you know more than the others of your county, come to the society and instruct them; if you know less come and learn of them. You thereby become more learned and correspondingly more skillful. The frequent association in your society the better acquaints you the one with the other. You see the faults of the others and in turn are made conscious of having similar ones; you recognize their virtues, you grow more charita-

ble toward one another; you realize that you are not competitors but are colleagues working together for the good of mankind.

The people notice with wonder this pleasant but unusual relation existing among you, and they appreciate you as never before. You become a potent factor in the affairs of the community in which you live. Your legislators when asked to support certain measures which are to come before that body will not refuse, for they see that you are no longer backbiters and dissenters but are co-workers in one great cause for the good of your fellow man.

It is well to devote occasional meetings to the discussion of the business side of the profession. Having become better physicians, you are entitled to greater compensation. My experience in the work of organization convinces me that it is not best for the profession to have a compulsory free bill, and they are indeed a stumbling block in the way of a complete organization, yet I do think it wise to have a reasonable fee schedule suggestive but not compulsory, and we should discuss the most expedient ways and means of collecting these fees. The majority of the dead beats can be taught to be good pay clients and so much more appreciative, if we will only work together to accomplish that end. Just as long as Dr. A will go to see a patient lest he call Dr. B, and both knowing that the fellow owes Dr. C a large bill of long standing and will not even make an effort to pay it, just that long will our profession continue to be a poorly paid and much imposed upon profession.

The average physician works much more assiduously than he ought to work, and his amiability is spoiled if his life is not shortened by the frequent night calls he is compelled to answer. 99 per cent. of night work is absolutely unnecessary, and if we will only make a united effort, we can soon educate the people that they can wait until a reasonable hour to call a physician. Our evenings are interrupted far more often than necessity requires. We should be permitted to have a little leisure with our families after coming home from a very trying day, too, we need the evenings for study and reflection. The people can be educated to allow this, and we should begin now to do it. Our Sunday work is entirely too great and should be confined to the cases really needing attention on that day. This can be arranged in due time by the proper united effort on our part.

I now wish to call your attention to a few of our needs as regards legislation: We should have a law so defining the practice of medicine as to require the bone rubber, the so-called Christian Scientist, and all such ilk to show equal evidence as we do, of qualification to practice before they are allowed to treat disease.

A law making the communication of the physician and patient privileged, and another defining expert testimony and providing a fee for such testimony, would save us no little embarrassment at times as well as enrich our coffers to some extent. Not a few of us know how delightful it is to have to hang around the court house till the court sees fit to have us on the stand for the lawyer to do his best to either make us appear foolish, or to perjure ourselves, that he may gain his case with the jury.

The State Board of Medical Examiners and the Board of Health should be men selected by us from our Association, and the county boards should be controlled by the county societies.

We are sadly in need of a sanitarium for tuberculosis. Some of us have done excellent work to that end but the legislature apparently ignores us.

Our Boards of Education should have at least one physician on every board, that the proper methods may be adopted for teaching the children how to prevent soil pollution and infection therefrom as well as the dangers of infection from other diseases.

I will not take up more time on this subject though there are other matters of importance that we should consider in due time.

Now, gentlemen, all of these can not be had in a year or even five years, but if we will get our 146 counties so well organized that they will have the desired influence with their legislators, we will accomplish all of this and more.

Just here, let me say that there seems to be a tendency on the part of many to search for new measures to be brought before the legislature, and all of them possess some merit. I earnestly ask that you leave all these alone for awhile and advocate with all your might such laws as are most needed for our welfare and the others will come in due time.

A medium of communication with the members of the Association would facilitate the work of completing our county organizations as well as keep up a renewed interest in the socie-



ties. I respectfully recommend that you authorize your Council to enlarge the Bulletin and arrange for the publication from month to month of such matter as will encourage the work of organization. The Bulletin will become a monthly letter from the officers of the Association to the members and will foster the idea that it is the organization of the profession for the benefit of its membership, and each member will feel and show a greater interest in its affairs.

Now, fellow members of the Medical Association of Georgia, while much depends upon our officers as to how successful and useful this organization becomes, yet it can never be complete without the co-operation, support, and sympathy of every individual member. I can not tell you how often your President has yearned for an encouraging word or an expression of sympathy, and I am sure he could have done better work, if you had but thought to offer your sympathy and support. I trust you will go home from this meeting fully resolved to in future give your hand and heart to the perfection of this great work.

Ours is the Empire State of the South, let us make it the banner State of the Union in medical organization.

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## A REPORT ON ONE HUNDRED AND TWENTY KNEE JOINT OPERATIONS.\*

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BY MICHAEL HOKE, M. D., AND C. R. ANDREWS, M. D., ATLANTA, GA.

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You will be pleased to know that I have no intention of wearying you with a prolonged, detailed report of the knee joint operations mentioned in the title of this paper. It is not often that the general practitioner has the opportunity to see the inside of the joints when affected with the various conditions which have necessitated the operations. As the general practitioner is usually the first one to come in contact with these cases, it seems to me that if I select certain ones from the number, describe the conditions found in the joints and state the results obtained, it may be of value to you. Ninety-seven of these cases were the results of toxic arthritis. I wish to take a few of these

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and show in connection with the clinical history, the various degrees of inflammation of the joints in this process, from the slightly inflamed to those in which the process had made further advancement, in which extensive changes had taken place in the joint tissues with consequential deformity.

Case 1. Miss H.—This young lady had had indigestion for a number of years before she was seen by me. When I first saw her, both knees were swollen, the left slightly, the right considerably so. There was fluid in the right joint. A diffuse thickening of the joint capsule was palpable, and in the upper, inner quadrant a small mass could be felt. She had been "rheumatic" for some time. The fingers were inflamed and she also had pains in the other joints. The right knee was slightly bent. Palliative measures helped her somewhat, but the right knee remained enlarged. Her family took her to Hot Springs. She returned with the knee still swollen. She was then content to have the operation.

The joint was opened and a small amount of fluid evacuated. The synovial surfaces were injected, showing minute ecchymosis, and the small villi were enlarged so that the synovial surfaces showed minute elevations. The margins of the cartilage of the head of the femur were injected. Some of the blood vessels here were as large as a pin. The surface of the hyaline cartilage, instead of being white and glistening, presented a very fine tracing of capillaries. The mass in the upper, inner quadrant was a localized thickening of the joint capsule in that area. This tissue was removed and the joint washed out and closed. The subsequent history of this case was tedious, the main factor being the gastro-intestinal disturbance manifested by nausea, vomiting, now and then much gaseous distention, and obstinate constipation. The knee joint itself continued to be painful for a number of months, though the swelling entirely disappeared subsequent to the operation. It was necessary for this patient to wear a brace for a number of months in order to maintain the anatomical position of the leg.

This was one of the toxic joints in the earliest stages of inflammation. A microscopic section of the tissues excised showed an inflammation which was characterized mainly by infiltration around the blood vesels. This was one of the first joints operated upon. At that time the writer felt that the cause of the in-

flammation was some poison circulated in the blood. This patient has been arthritis now and then since, but the end result was a normal joint with normal function. This case illustrates the earliest beginning of the toxic inflammation of the joint. At the time this case was studied and treated, the nature of the toxic process was not known. However, it was thought to be in the intestinal canal, and the line of general treatment was based on this conception of the nature of the disease.

Case 2. Age 21.—For about a year the right knee had been sore, following an injury. The joint had been treated with plaster-of-paris without avail. At the time she was seen, it was in the same condition that it had been for several months. The knee joint contained fluid and felt flabby, the swelling being chiefly above the patella. The general condition of the patient was of interest. She had had abdominal pains for some time, so severe at times as to simulate appendicitis. The least exertion brought on fatigue, and her complexion was muddy. The joint pains were confined to the knee. She was nervous and slept badly. On entrance to the hospital, her temperature ranged between 98 and 100. She was kept in bed for several days on a fermented milk diet. Soon the temperature became normal, the abdominal pain disappeared and her complexion cleared up. Her general condition was also much improved.

The knee joint was opened and a quantity of fluid evacuated in which there were numerous coagulae. The margins of the cartilages were congested. The capsule of the joint was thickened about 3-8 of an inch. No tissue was excised. The joint was washed out and closed. Recovery was uneventful. Fifteen days after the operation there was 90 degrees of voluntary flexion, and she was allowed to go home. When she left her general condition was excellent; was not nervous; had no abdominal pains; the knee did not hurt and she walked quite well. Off and on for several months, during which time she carefully dieted and exercised, there was now and then a return of the abdominal pain and pain in the knee joint, though recovery at the end of several months was complete.

This is also one of the early cases, exhibiting not only the evidence of early inflammation, but the presence of coagulae in the joint, which, had they not been evacuated, would have certainly been an irritant to the joint, keeping up the exudate with-

in and the joint pains. The study of the stools and urine disclosed the usual evidence of chronic intestinal putrefaction. It illustrates also what we have often observed in these joint cases, in which the patient suffers profoundly from toxemia, that attacks simulating appendicitis are common, as is also appendicitis itself. There have been ten cases out of a hundred joint cases in which the appendix had been removed, and in which there was no doubt about the involvement of the appendix.

Case 3. Lady, 45 years old.—Several years previous to the time that I first saw her, she had had attacks of sciatica which would confine her to the bed for a short period. Then the left knee began to give her trouble, so that in the course of time she began to have attacks of excruciating pain in the joint. A surgeon at her own home made a diagnosis of "floating bodies," and removed half a dozen of so-called "joint mice," which are cartilagenous bodies produced by the formation of cartilage in small polypi which drop loose from atrophy of the pedicle. This gave some relief, but the joint was still subject to attacks now and then. Often she would wake in the night and in turning over the joint would become locked, and she would be stricken with severe pain in the joint. She was obliged to walk with crutches. In the inner border of the patella there was something palpable which slipped under the finger when the joint was flexed and extended.

The joint was opened and a piece of cartilage, still hanging to a pedicle, half an inch long, was found at the site where something had been felt. This was taken out. The cartilagenous surfaces of the femur and patella were normal, but where the cartilage joins the osseous part of the end of the femur, there were minute osteophytes, about half the size of a match head, which studded this line. They were not large enough themselves to produce any mechanical disturbance in the joint and were, therefore, let alone. The capsule of the joint was diffusely thickened, though not to any great extent. It was therefore not disturbed. The joint was closed, and she made an uneventful recovery. This patient has been in good health, and with general care and dieting, is now in excellent condition. The only thing that has been done to her since the operation was to fit her with a belt for sacro-iliac motion, the latter keeping up a certain amount of backache. This patient's excreta showed

positive signs of intestinal putrefaction.

This joint illustrates a little further progress of the process, at this stage being associated, not only with evidence of thickening of the soft tissues, but with a hypertrophic process at the junction of the cartilage and the osseous portion of the bone.

Case 4. Lady, 45 years old.—This patient had been subject to chronic arthritis for 25 years, and had visited the Hot Springs every year. Both of her knees were involved. She came under my observation for the reason that in attempting to cross the right leg over the left, the right knee became locked and she was unable to unlock it. She had a gastro-intestinal history. There were Hebedens nodes on the fingers. The locked knee was very much thickened and enlarged, and had a boggy feeling, and two osteophytes could easily be felt. Likewise, too, one could squeeze under the finger in palpating, things that felt very much like varicose veins, the characteristic feeling of fringes.

The joint was opened on both sides and immediately that the capsule was slit, there popped out into the wound, a mass of worm like fringes. There was a most intense congestion of the soft tissues. The capsule itself was 1-2 thick, this thickness being made up of fibrous tissue. The joint was divided up into compartments by adhesions which ran across from the anterior to the posterior surfaces. The margin of the femur was studded with osteophytes, and the locking of the joints was due to the catching of a large osteophyte on the external condyle of the femur with a similarly situated osteophyte on the margin of the external tuberosity of the tibia. These were chiseled off and motion was again possible. The fringes were all excised. A plastic operation was done on the capsule of the joint after this fashion. The external fibrous capsule was separated, and the synovial membrane proper was separated from the subsynovial mass of fibrous tissue which was carefully dissected up from the line of incision to the margin of the patella on one side, and from the incision to the attachment of the capsule on the external point on the other. The two surfaces were then plastered together, reducing in this way the extent of its original thickness and preserving the synovial surface intact. The recovery was uneventful, the joint, however, requiring massage and necessitating the use of a brace for several months. She returned about a

year and a half afterwards with no thickening, no pain and a voluntary motion of about 70 degrees.

In this case we have exhibited further what may happen to the longer standing inflammations than in the cases previously described. One sees here a marked limitation of joint motion and the actual locking of the joint, the villi reported in the first case, having in this instance grown in size, varying in length from 1-4 of an inch to 2 inches. One sees the greater length of time necessary to restore the joint to its usefulness; also the permanence of the result, even in the advanced cases when the joint is freed from all of its impedimenta and again allowed to participate in its normal functions, this being motion without deformity and capacity to bear weight without pain. An interesting thing here was that previous to the operation, the left knee, which was not operated upon, was regarded by the patient as being her "good knee," and when she returned for her last visit she stated that the knee upon which the operation was done and which had been the "dreadful knee," was now the good knee. She was, however, unwilling to have the left knee operated upon though it needed it.

Case 5.—This patient had been subject to "chronic rheumatism" for many years, many joints having been involved. His toes were twisted out of shape, flexed and dorsally dislocated on the heads of the metatarsal bones. One ankle was swollen and both knees very much enlarged, boggy to the touch, presenting osteophytes and permanently flexed about 15 degrees. There was also palpable a hard mass. The right elbow was involved, being very much swollen. The fingers were enlarged. There was pain in the spine and under the shoulder blades.

The right knee was opened. There was fluid and coagulæ in the joint. There were numerous adhesions and a great mass of fringes which I exhibit to you here to show the formation and enlargement of the normal villi. The capsule was thickened and there were masses of fatty tissue which had formed in the upper part of the capsule just in front of the last two or three inches of the shaft of the femur. These masses were excised. There were, relatively speaking, craglike projections of bone and osteophytes standing out from the margin of the patella and the margin of the condyles. In the patella groove the surfaces were smooth as they usually are in the joint where there is present

the gliding of two bone surfaces. The hypertrophic enlargement usually takes place at the margins of the joint, as spoken of in the recitation of the above cases. The subsynovial tissue, dense scar tissue in nature, was removed after the method stated above. The hemorrhage was so great that it was necessary to gather up all margins of the incisions with through and through sutures, gathering up the blood vessels collectively rather than individually as the flow was mostly an ooze. The margins were then united. A small drain was put in the joint. There was a tremendous amount of serous ooze following the operation, but the joint recovered without any trouble.

This case illustrates the formation of fibro-fatty tissue between the capsule in front of the shaft of the bone as well as the formation, to an extreme degree, of osteophytes, fringes, polypi, adhesions, coagulæ and the outpouring of fluid. I am not able to state the result in this case, as the patient passed out from under my observation, not being willing to undergo subsequent operations on the other joints.

Case 6.—A lady with a gastro-intestinal history for twenty-five years. Several years previous to the time that she came under observation the left knee gradually swelled and went through a very acute inflammation, being very large and red, painful and flexed for a month. She was confined to her bed for two or three months. She was treated by an orthopedic surgeon in the north, the line of treatment being plaster-of-paris casts, burning with cautery, etc. At this time very little was known about knee joints of this type, and the treatment was the treatment then in vogue. When seen the joint had been permanently flexed somewhat for about two years. There was no fluid in the joint; there was no swelling except on either side of the patella tendon.

The joint was opened and there was a dense mass of fibro-fatty tissue, very vascular, on either side of the patella tendon. This was at the site at which the joint had been most painful. The surface of the external condyle had been eroded, and there was a flat place, larger than a quarter of a dollar, of ivory like consistency. The scar tissue was dissected out, the joint capsule being smaller than to this extent. Recovery was **uneventful**, though it was necessary to treat the joint for four or five months. This patient was so much improved that one year ago she traveled

all through Europe, walking as tourists do through galleries and sight seeing. When first seen she was bedridden. There is about 70 degrees of voluntary motion present, but the joint cannot be quite straightened. She walks with a scarcely preceptible limp.

This case illustrates the erosion of the cartilage that occurs sometimes in the progress, as likewise the formation of dense scar tissue.

Case 7.—This patient gave a gastro-intestinal history existing for a number of years. Several years previous, the left leg had been amputated just above the knee on account of a tubercular (?) infection of that joint. During convalescence the left hip joint became ankylosed so that she had an ankylosed stump on that side. Several months after the operation the right knee became swollen, and when seen it was enormous, boggy, very much swollen below the knee and much atrophied above the knee. The right ankle was also very much swollen. She was emaciated, and the complexion had that sallow, brownish hue which goes with intense albuminous putrefaction. The stools were very, very foul. She presented all the general signs of toxemia.

This joint was opened on either side of the patella. A double handful of angry, inflammatory tissue was removed. Wherever there was a crevice into which this tissue could protrude, it had formed. There was nothing nice about this operation; it was simply a hacking away of chronic, inflamed tissue, masses of fringes and polypi. The feature here which is presented and which is not presented in the other cases is this, that the lower end of the femur was so soft that the slightest pressure upon the cartilagenous surfaces of the end of the femur would indent it. It had the feeling as if the end of the femur were cystic. This was not disturbed. The joint was closed. A great deal of suffering followed the operation; every stitch hole abscessed. The stitch infections were attributed to the low vitality of the patient.

This stitch hole infection illustrates a point of extreme importance in the handling of toxic joints, namely, that these toxic patients all have lowered vitality and all are subject to inflammation of other parts of the body, than joints, as is evidenced by the persistent presence of bronchitis, trachitis, pharyngitis, nasal:



infections, dactylitis, colitis, appendicitis and most every form of —itis that one might mention. The clinical meaning of it is this—that previous to the operation on cases which present evidences of toxic inflammation, one should be extremely careful to delay the operation, if possible, until the patient shall be placed in a suitable physical condition to stand it. I have operated upon cases in the sixties, who, when they presented themselves for treatment were in a state of extremely low vitality, and who, after they had been put on fermented milk and a soft diet and rested and slept in the fresh air for days or weeks as the case might be, until they were in good condition, their incisions would heal with as little disturbance as a scalp wound made under the best aseptic technique.

I exhibit here two knee joints which were the portions of a leg amputated by Dr. Armstrong several days ago, from a patient who had been a sufferer from arthritis deformans for a great many years, the operation being necessitated by gangrene of the feet. These specimens show the most extreme destruction which takes place around the joint in long standing process. You will see that the joints are entirely destroyed, distorted and deformed, that there is hardly any dense bone at all, the shaft of the bone and the end being simply a fine shell containing a mass of fat, and the spongy bone structure as coarse and about as dense as mosquito netting. Quite likely the condition of affairs at the lower end of the femur in the case last mentioned was about as seen here, plus the persence of enormous masses of highly inflamed tissue between the femur and the tibia as described above.

Case 8.—The following case will illustrate the formation of tumors in the knee joint. This class of cases is not so frequently seen as those with minute polypi and fringes, but they do occur. This woman, about 38 years of age, had had attacks of "rheumatism" in the past which were usually severe. Several months previous to the time she was observed, she had an attack of "rheumatism" in the left knee from which the knee did not recover, and the time when she first came under observation, the joint was enormously swollen, full of fluid and very tense, so much so, that nothing in detail could be made out by palpation. The swelling was chiefly above the patella. When the swelling is mainly confined to this locality it usually indicates the formation of a great deal of

thickened tissue between the posterior capsular surfaces and the femur.

This joint was opened and about a pint of straw colored fluid removed. Loose in the joint was a tumor about one-half inch long and one inch thick, oval in shape. This was evacuated. There were membranous adhesions between the surface of the joint and the capsular space had been very much distended upwards so that the capacity of the joint was very much increased. At this site, at the upper border of the joint, there were masses of fibro-fatty tissue. This was not an isolated mass but had involved the capsule of the joint to such an extent that the upper border of the capsule was excised along with the mass. There were several small polypi which were also removed. The capacity of the joint was reduced by this excision of the excess in the upper portion, everything was sutured and the joint closed. Her recovery was uneventful, with a normal degree of motion and function without pain.

Case 9.—This case was that on an extraordinarily stout woman who had been suffering with so-called "rheumatic gout" for a great many years, presenting spurs on the tarsus and both knees being so extremely painful that she could not walk about the house, that she would wake in the night on account of this pain. The pressure of the bed clothes even caused sufficient pain to keep her awake. Her distress was extreme.

From both knee joints fatty tumors were removed which were attached to the joint surface by pedicles. These masses were not very large, one being about two inches long by one-half inch wide, irregular in shape. A microscopic section showed globules of fat with intervening fibrous tissue trabeculae in which numerous blood vessels ran, some with periarteritis and almost obliterated, and others showing a more recent periarteritis.

The interesting feature about this case was that she was rheumatic, using this word in the general sense, and that after the operation she would have attacks of acute pain in the points now and then, which would always be relieved by purgation and anti-rheumatic remedies, these measures previous to the operation not having any effect upon her at all. The case illustrates the formation of fatty tumors in the joint, and the relief afforded by operation and the hopelessness of general treatment when there are masses of tissue within the joint which can only be relieved

through an excision. This group of cases illustrates quite well the condition of affairs most usually found in the toxic inflammations of the knee joint, and though there are a very much greater number of cases of this nature in the total number operated upon, yet these cases will serve to furnish the details of things found within the joint and the results to be obtained by operation. Of course, the operative procedures did not entirely terminate the treatment, in all instances there being a certain amount of post operative treatment varying in length of time from two weeks to one year. All that the operation can accomplish is to get rid of the products which, by their presence, are causing pain and interfering with the normal use of the joint. Subsequently to the operation it is necessary to utilize such measures as massage, manipulation, passive motion and apparatus to maintain the anatomical position of the joint while the leg is regaining its power of motion; to diet the patient properly and to maintain proper hygienic surroundings.

Case 10.—This case, in which there were several in the group, illustrates the formation of a good knee from a knee almost completely ankylosed from adhesions. This lady, a very large, stout person, stuck a pair of shears into the knee from which the joint was infected, this having lasted a number of months. At the end of this time the knee was bent almost to a right angle with extremely little motion present. She had considerable pain, particularly internal to the patella tendon when pressure was made at this site.

There was a mass of scar tissue just internal to the patella tendon which was removed by operation. While removing this, observation was made upon the character of the interior of the joint. The joint surface was entirely obliterated except the contiguous surface of the femoral condyle and the tibial tuberosity. The joint surfaces were adherent by a rather delicate grade of fibrous tissue. By manipulation, the patella was made movable, and by forcible flexion and extension and tenotomy of the biceps tendon, the amount of motion was increased. The joint was then sewed up. The subsequent treatment in this case consisted in the use of apparatus and massage, of passive hyperemia induced by superheated air. This extended over fourteen months and at the end of this time she was able to walk without apparatus and had voluntary flexion of 45 degrees.

One other case in this group illustrates a feature which is rather uncommon. This joint had been obliterated by gonorrheal infection. There was about 10 degrees of motion which was perfectly free, but at the end of the arc of this motion the joint would suddenly lock as if two obstructions came in contact with one another. The skiagram did not show any bone interlocking, so it was finally concluded that the limitation of motion was due to the presence of an extremely short patella tendon. This tendon was split lengthwise and the two ends spliced after the joint had been forcibly flexed. At the end of three weeks passive motion was begun with the production of voluntary flexion and extension, sufficient to do away with the stiff legged walk.

Out of seven cases of this nature, five were successful with the production of good motion of the joint without pain being experienced by this motion. The other two were failures.

I have operated upon one joint which presented bony ankylosis from so-called "rheumatism." The skiagram showed the union between the femoral condyle and the tibial tuberosity. The joint was opened on both sides, a flap dissected from the under surface of the tissue, and the joint chiseled loose. The joint was then sewed up in a slightly flexed position. Following the healing of the incisions there was slight motion, but considerable spasm when an effort was made to move the joint. An anaesthetic was administered and flexion producing 20 degrees of motion in the joint while under the anaesthetic, was obtained. This patient did not remain under observation, leaving the hospital one night with her belongings without saying "good-bye." I was never able to hear from her afterwards. It would have been extremely interesting to follow up this case as I believe that good motion could have been accomplished had she submitted to further after treatment.

Case 13.—This case illustrates a condition found in gonorrheal infection. This young man had both knees affected, having been observed after the disease had existed for six weeks. The right joint was swollen and contained a small amount of fluid as was evident by fluctuation, and the tissue on either side of the patella tendon felt boggy. The left knee was slightly swollen. It is of interest here to note that following urethral irrigation, the pain in the left knee would disappear, while it had no influence upon the right knee. It was decided that it was necessary to operate upon this joint.

The fluid evacuated was of a gelatinous nature, some of which looked as if it were softened coagulæ, being mushy in consistence and quite clear. The surfaces of the joint were, of course, inflamed, being very much injected with small enlarged villi, not sufficiently enlarged to be removed. The normal ligamentum mucosum was very much enlarged, both in length and breadth, and the pouches on either side of the patella tendon were masses of recently formed granulation tissue. Part of the ligamentum mucosum was excised. The recently formed inflammatory tissue was excised also, and the joint cleared of all fluid and closed without drainage. Recovery from the operation was uneventful. It took about three months to regain the normal motion in this joint, and when last seen there was only a slight limitation of the normal motion, and the joint was normal in size, there being no thickening present.

Case 14.—One excision may be of interest. This was an old tubercular knee which had been incised in Italy by a very distinguished surgeon in Rome. The bones had been wired together. In the incision which I did, I first took off a small amount from the end of the femur, hoping to get away from the diseased tissue. The saw passed through good tissue for the most part, yet it bisected one area about one-half inch in diameter, with a cheesy centre. Wishing to get to a healthy surface, if possible, it was sawed a little farther back, and though good areas of bone were passed, the saw passed through a small focus as before. Another level was tried and another with the same result.

This illustrates that in chronic bone infections which have been going on for years, there are foci scattered throughout the bone with intervening areas of good bone. The patient had been in a very much depleted condition and did not do well. The incisions healed, but his general condition was still bad. On account of this the leg was amputated about a month afterwards. The recovery of his health was very rapid, so that in two months he was ruddy and strong again. I think it illustrates that in the chronic bone infections of this nature, where the body at large seems to be suffering from the bad effects of the local disease, it is better to get rid of the disease entirely than to try to preserve the joint which will certainly be a source of annoyance, and the probable source of a more wide spread disease.

There was one amputation on an old lady who had an inflam-

med knee, which was thought, at the time the joint was opened, to be a chronic toxic joint. Cultures showed staphylococcus aureus. The drainage which was established did not seem to relieve her of the general ill effect upon the body at large and amputation was advised on this account, though there did not seem to be, so far as the joint itself was concerned, any hurry for the amputation. That the amputation was wise was shown by the fact that the infection had extended up the thigh about five inches into the planes of the fascia below the muscles. Here again recovery followed rapidly upon the removal of the infected joint.

There still prevails in many quarters, a feeling that operations upon the joints are to be dreaded through fear of infection, through fear of possible ankylosis of the joints. I desire to say that the cavities of the joints can be invaded with even greater freedom than any of the other closed cavities of the body, that where there is no pre-existing infection of serious nature, you should not have the slightest dread of damage to the joint, and that increased motion is the rule rather than limited motion. I must acknowledge, however, that there is room for the display of the most varied grades of judgment, not only in the operative procedures that are done upon these joints, but in the subsequent management. I may say that in joint operations, without the most skillful judgment in the management of the post operative treatment of the joint, there is liability of failure in accomplishing the restoration of the joint function. For example—often times massage is extremely important during one week of the post operative treatment, when the same massage given at another week would do the joint damage and retard its progress. I may say that one must have familiarity with the personal characteristics of the joint. There is a something which is hard to describe which we can only know through intimacy with them, which enables one to be extremely conservative at one period of its management, and extremely radical at another period of its management, and only by the most careful attention to details in the management of them are they restored to usefulness.

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The South Carolina Medical Association held its annual convention at Anderson, April 14 to 17 inclusive, under the presidency of Dr. Le Grande Guerry, Columbia.

## TUMORS OF THE BLADDER.\*

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BY ALFRED L. FOWLER, M. D., ATLANTA, GA.

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The word tumor is a very ancient name and simply means a swelling. Clinically, the word is not likely to disappear, notwithstanding it has lost its importance to the pathologist.

Our knowledge of tumors of the bladder, the result of long continued pathological and experimental research, is a modern acquisition and the perfection of our diagnostic means is even more recent.

A satisfactory classification of these growths, in every respect, is difficult. The most natural method is to divide them into two classes, benign and malignant. But even this is attended with great difficulties.

Of those of the first class *papilloma* is the more common and which may be sessile or pedunculated, single or multiple. This class is generally multiple and grows from a common pedicle as do the branches of a tree. These branches, or villi, are composed of a fine stroma of connective tissue, each branch having a loop of blood vessels extending to its extremity, and covered by several layers of epithelium.

When the bladder is distended with fluid these processes unfold and float like aquatic plants in deep water, as they are seen to do when viewed through the cystoscope.

When the connective tissue stroma is particularly well developed it is called a *fibrous papilloma* and is typical because a collection of papillary formations rests upon a more or less thick pedicle; and when the branches are composed of thread-like processes, so gracefully described by Thompson, it is known as a *fimbriated papilloma*.

Clinically, these tumors are generally benign or, as the French aptly say, good natured. But we must bear in mind that this is

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\*Read before the Georgia Medical Association, Fitzgerald, April 15-16-17, 1908.

not always so. They may be benign in their superficial portion while their deeper parts or base is malignant.

In the benign or good natured growths the connective tissue stroma arises directly from the mucosa or sub-mucosa, while in villous carcinoma there is a small-celled infiltration into its base, and an irregular proliferation of epithelium penetrating its deeper parts.

Villous papillomata are met with anywhere in the bladder, even in a diverticulum, but generally they are situated about the trigonum.

Among the growths of the second class and of greatest importance are, *Carcinoma* and *Sarcoma*, which are met with frequently. They occur in various forms and are seen as huge masses growing into the vesical cavity or even so minute as a slight infiltration of the bladder wall.

Of the two, carcinoma is the more common. It may arise in the form of hard or medullary nodules or it may appear as a diffuse flat infiltration, involving an extensive area of the bladder wall.

Villous carcinoma may occur primarily in the renal pelvis and secondarily in the bladder as a result of villous tufts becoming detached and transported to the bladder where they become implanted.

We distinguish, according to their structure, the scirrhus, medullary, and alveola types, cancroïd and melanoma. The epithelial layers, histologically, are usually the starting point, less frequently the glands of the mucosa.

Of these the carcinoma simplex, usually termed scirrhus, is the most frequent form met with, and in which there is an abundance of fibrous tissue elements, while the specific cell elements are less prominent. Those rich in cell elements, carcinoma medullare, represent the softer forms, and are by no means rare. The most obvious characteristic of this growth is its great tendency towards ulceration at an early date.

The alveolar, or gelatinous cancer, particularly malignant, shows a characteristic colloid degeneration of the epithelium.

The cancroïd contains the typical epithelial pearls.

The pigment cancer, melanoma, is characterized by a deposit of black pigment in its cells.

Sarcoma is one of the rarest growths of the bladder. Out



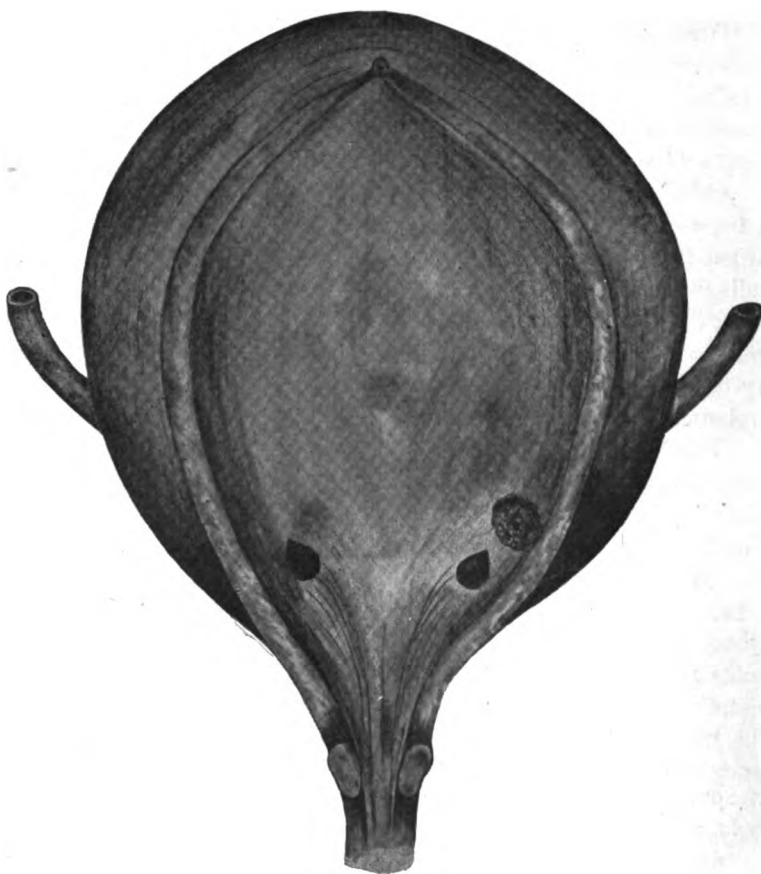
of eighty-two vesical tumors. Albarran only found two cases of sarcoma.

This growth is usually seated in the fundus and is composed of spindle or round cells. Borst divides this form of growth into simple sarcoma and the highly developed sarcoma. In the former, he includes the round cell and spindle cell sarcoma, while in the more highly developed types he includes fibro-sarcoma.

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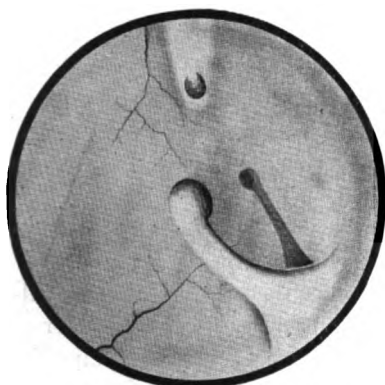
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#### TUMOR OF THE BLADDER.

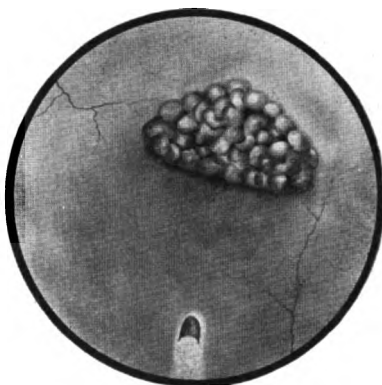


*Case Mr. A. W. H. (Death from Hemorrhage)  
Showing Sessile Papilloma Near Left Ureter.*

CLINICAL CYSTOSCOPY.



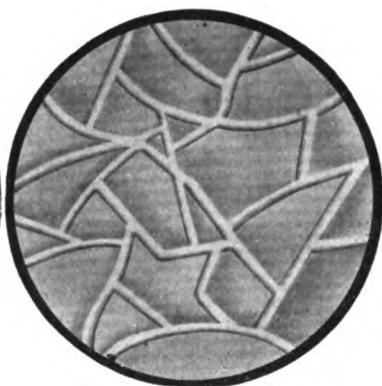
*Pedunculated Tumor.*



*Cancerous Tumor.*



*Villous Tumor.*



*Trabecular Bladder.*



*Papillomata.*



*Sessile Papilloma.*

lympho-sarcoma, myosarcoma, myxosarcoma and chondro-sarcoma.

The former types are derived from an excessive growth resulting in a secondary filling up with embryonal cell elements.

The second group show manifestations of a slight degree of degeneration, unmistakable in their relationship to the various tissue types of normal tissue growth.

Concerning the causes of tumors of the bladder little is known.

Prolonged irritations, such as chronic catarrh, vesical calculus, prolonged catheterism and various other ingenious theories have been propounded yet we can not satisfactorily explain the unknown factor in their production. Histologic study demonstrates the method of epithelial growth, but the proliferation of the epithelial bud is an effect, not a cause. It has been observed too long, perhaps, to be altogether a coincidence, that persons working in dye establishments are more prone to vesical tumors than others.

*Symptoms.*—In the majority of cases the first, the last, and the only symptom of a tumor of the bladder is hemorrhage.

It may be stated, clinically, that the more villous the tumor the more profuse the bleeding.

In tumors covered with a normal membrane, as myoma and fibroma, hemorrhage is the exception.

A profuse hemorrhage unaccompanied by any other symptom is pathognomonic of either a renal or vesical neoplasm.

Pain and dysuria are secondary. Retention may occur as the result of a large clot or tumor obstructing the vesico-urethral opening.

Cystitis too, is generally secondary to the hemorrhage and dysuria is concomitant to it.

The urine may be entirely normal or it may contain red blood cells, macroscopically or microscopically.

Occasionally small particles of the tumor, even as large as a pea, are voided. This happens now and then in papillomata or good natured tumors, but rarely in the malignant growths.

*Diagnosis.*—If the tumor has infiltrated the bladder wall, palpation through the rectum in the male or through the vagina in the female, will disclose it, provided the infiltration is exten-

sive. If not extensive this method proves negative because it may be so superficial that it can not be felt.

On the other hand cystoscopy gives us positive and reliable results. It is in diagnosing tumors of the bladder that the cystoscope has proved so triumphant. Usually it requires only a glance to determine their presence. Further, we actually see the tumor, its size, shape, and location and whether it is villous, pedunculated or sessile.

It is an object of much attention for us to bear in mind that unless the exact location of every villous tumor is definitely determined by cystoscopy, before operating, some of them will be overlooked.

We know that many of them may be seen floating in the liquid medium yet when the bladder is opened unless their location is known beforehand, they are frequently undiscoverable.

For determining the site of villous growths, which by the way are seen as beautiful fantastic creations, apparently growing upon a sandy shore, the irrigating cystoscope should be employed because its stream causes a continuous change in the field of vision thereby facilitating our study of the condition and location of the tumor's pedicle, and which is of great value to us subsequent to operation.

While it is generally true that we nearly always find vesical tumors situated adjacent to either the mouth of the urethra or one of the ureter openings, nevertheless it is advisable for us to employ both the direct view and the prismatic cystoscopes to avoid the possibility of error.

For examining the base and posterior wall of the bladder an instrument of the Cabot type is to be preferred. For examining the fundus the Bierhoff-Frank irrigation Cystoscope or the Otis observation cystoscope is more desirable, while if the anterior wall and prostate are to be examined the retragrade cystoscope will serve our purpose best.

The characteristics of many of the different vesical tumors, as seen through the cystoscope, have been very beautifully reproduced for me from cystoscopic photographs by Mr. S J. Bernolak who has taken sufficient interest in this line of work to examine with me some of the pathologic changes occurring in the bladder. The interior of the bladder and its contents are easily photo-

graphed by attaching a miniature camera to the ocular end of the cystoscope. Perhaps the Nitze camera manufactured by L. and H. Lowenstein, Berlin, is the most serviceable as it is detachable and can be applied to any cystoscope. The Crammer Dry Plate Company of St. Louis, manufacture plates for it which only require 5 or 10 seconds exposure in a well illuminated bladder.

The different types of cystoscopes mentioned I take pleasure in handing you for your inspection.

If the tumor be in one of the ureters or kidney and not in the bladder, and blood be coming from it, the cystoscope will reveal the side involved because the blood can be seen issuing from the uteral opening of that side. Moreover, the ureters are easily catheterized by those of us who have given such work the requisite time and patience, and in this way only the urine from either kidney may be studied separately.

Cystoscopy, when performed in a diseased bladder; also obtaining the separate urines by ureteral catheterization, calls loudly for a professional cystoscopist and in the hands of a neophyte the cystoscope is an instrument to be dreaded. One case is reported simply to accentuate its dangers when in the hands of an inexperienced person.

*Sessile Papilloma.*—Mr. A. W. H., age 58; married; occupation, insurance clerk. About eight months ago patient discovered that he was passing clots of blood in his urine. His family physician, whom he consulted at that time, expressed the opinion that they were coming from the urethra. An internal medication was prescribed by his physician and the blood and clots ceased about as suddenly as they had appeared. Urine remained clear until August third, when blood and clots were passed three or four times daily for three days. Patient's physician ordered him to bed and prescribed adrenalin chloride internally, and irrigated his bladder daily with hot boric acid solution. Hemorrhage completely disappeared August 9th for a day, only to return in greater quantity the following day. His attending physician at first suspected the prostate as the probable cause of the hemorrhage, but as the prostate was about normal in size he was at a loss how to account for the hemorrhage in this connection. In his efforts to diagnosticate the cause he attempted to use an air dilating cystoscope, with which he was unfamiliar and with which he stated he was unable to make out anything. Unskilful

cystoscopy aggravated the hemorrhage and it had become serious. It was at this juncture that I was called into consultation. From all the data the physician was able to supply, I reasoned by exclusion, that in all probability the patient had a villous tumor. The next day his physician returned to my office stating that the patient's vitality was beginning to fail and that he was fearful of losing him. I recommended an aluminum sulphate irrigation, stating that if it failed to do good, a suprapubic cystotomy was the patient's only chance. To this the physician stated that he did not think the patient was in condition to stand a general anesthetic. I suggested local anesthesia, which had not occurred to the doctor, he remarking that that threw a new light upon the situation. Over two days were lost before family consented to the operation; meanwhile the patient was still passing clots and blood. We preformed a suprapubic cystotomy under local anesthesia. The bladder was swollen, protruded considerably above the pubic bone and was suggestive of the gravid uterus. Over two pints of clotted blood were removed. Bladder was irrigated with a hot saline solution and packed with gauze, wrung out in adrenalin chloride solution. Up to this time the patient had stood the operation well, but a quarter of an hour later a "sledge-hammer pulse" came on and the patient became irritable. No noticeable change for the next two hours, when the patient steadily declined and died—four hours after the operation. By the aid of a small incandescent lamp introduced through the suprapubic incision the autopsy disclosed a sessile papilloma nearly the size of a dime, located about an inch to the left of the left ureter, and which was not observed in the hurry of the operation.

To my mind this case illustrates very forcibly three important points: The danger of delay in desperate hemorrhage. The danger in clumsy cystoscopy. The danger of over stimulation from adrenalin chloride, particularly in a bladder that has lost its tone.

The treatment of tumors of the bladder is purely surgical and perferably by the supra-pubic route. Palliative measures are a waste of time and surgical intervention, in the vast majority of cases, is the patient's only hope.

928-929 Candler Building.

Bibliography: *Keys, Lowenheim and Bland-Sutton.*

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**'AMERICAN HOOKWORM'—UNCINARIASIS.\***

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**DEDUCTIONS DRAWN FROM TREATMENT OF 408 CASES.**

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**BY A. G. FORT, PH. B., M. D., LUMPKIN, GA.**

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Uncinariasis is a specific disease caused by the presence of the *Necator Americanus* in the intestine and characterized by a progressive anemia, various nervous disturbances, weakness and intestinal disorders; common to temperate, tropical and sub-tropical climates and usually easily cured by removal of the parasites.

We have but to refer to the transactions of the Medical Association of Georgia for 1903 and 1904 to learn how recent is the discovery of this intestinal parasite in our State. Since the articles of Dr. H. F. Harris in 1903 and Dr. Claude A. Smith in 1904, thousands have been treated in Georgia for this malady. While this is true, yet the relative number of physicians who recognize and treat it is indeed small.

Instead of thousands being treated, tens of thousands should have received treatment.

Doubtless this condition has existed in Georgia for numbers of years, yet it has been recognized as a disease only for the last six years.

Reports have come from all South Georgia of its presence. In Stewart county, southwest Georgia, I have, since April, 1904, treated 408 cases. If this is true of a hilly section of the southwestern part of the State it must be true of the moist, flat, warm sections.

All references in this article to the Hookworm apply to the one variety "*Necator Americanus*," described by Dr Stiles, who gave it this name, as follows:

"Uncinaria—Body Cylindrical, somewhat attenuated anteriorly. Buccal capsule with a ventral pair of prominent semi-lunar plates or lips, similar to *U. Stenocephala*, and a dorsal pair of slightly developed lips, of the same nature; dorsal conical median tooth projects prominently into the buccal cavity, similar to *Monodontus*; one pair or dorsal and one pair of ventral sub-median lancets deep in buccal capsule. Male, 7 to 9 m m. long;

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\*Read before the Georgia Medical Association, Fitzgerald, April 15-16-17, 1908.

caudal bursa with short dorso-median lobe, which often appears as if it were divided into two lobes and with prominent lateral lobes united ventrally by an indistinct ventral lobe; common base of dorsal and dorso-lateral rays very short; dorsal ray divided to its base; its two branches being prominently divergent and their tips being bepartite; spicules long and slender. Female, 9 to 11 m. m. long; vulva in anterior half of body, but near equator. Eggs, ellipsoid, 64 to 76 micron long by 36 to 40 micron broad, in some cases partially segmented in utero, in other (rare) cases containing a fully developed embryo when oviposited."

Under favorable conditions of heat and moisture, both being necessary, the ovum hatches out in about 24 hours. Each ovum producing one worm.

Fortunately these favorable conditions do not exist in the alimentary canal of a human being, so the number of parasites contained depends entirely on the number that gain entrance from without. In about 5 days the larvae reach maturity and is encysted. This is its infective stage. It remains thus dormant until it gains entrance to its human abode where it is said to reach full size and maturity in about five weeks.

There are two modes of infection—direct ingestion of the larvae per os and indirect by finding their way through the skin to the veins and lymphatics and thence to the intestine. For a more thorough explanation see "Report of Commission for the Study and Treatment of Anemia" in P. R. 1904.

Moist, sandy, warm and shady places are the best fields for the development of the larvae. These conditions exist about many gardens and around "horse-lots," and homes. There, on the vegetables oftentimes lies the dormant larvae and when ingested he readily finds a welcomed home. The children often play, barefooted, around the "horse-lots" and grounditch,—mazamorra—a mere symptom of the infection, is very common. Then there are a few scattered here and there who are dirt eaters and they get a thorough charge of the "Hookworm."

Out of 408 treated by me during the past four years, 302 were males—181 whites, blacks, 121. Of the males all had history of repeated attacks of ground itch—mazamorra. Of the 106 females, 100 were blacks and 6 whites. 54 gave history of ground itch—mazamorra. It might be interesting here to state



that two of these were discovered during an attack of typhoid fever.

The symptoms of the disease usually vary in proportion to the number of offending parasites and to the length of time they have been in the individual, although we occasionally find intense symptoms with mild infection. They usually present themselves to you for treatment for one of four things—indigestion, bronchitis or consumption, weakness or swelling of their ankles.

You find them sallow, tongue and conjunctive pale—muscles flabby and soft though they seem to have lost none in weight.

All have a "Pot belly." There is usually a slight haemic murmur over the heart and coarse rales heard over the lungs. Their faces are pale and haggard and they come in looking like the "last rose of summer." They tell you they are easily tired, have no energy, they eat a large quantity and every fall they give out completely. Usually they suffer from pains in their epigastrium—constipation and diarrhoea alternating. The feces are usually slightly reddish in color although it may have any appearance and contain the ova.

If in children their physical development is below par. In young women they suffer from amenorrhoea or dysmenorrhoea. 356 of the 408 treated gave history of repeated attacks of ground-itch—mazamorra.

It is the exception for one to perspire. The temperature has in all uncomplicated cases been subnormal, pulse always rapid and feeble.

The diagnosis of no disease is so easy and sure. You have but to look at one suffering with this infection to make you suspect it and a simple examination of the feces under the microscope will tell the tale. The presence of the egg in the feces is conclusive.

It is well enough to call attention to the fact that this disease may exist in connection with many other diseases and care should be exercised to not attribute all symptoms to the Hookworm without due consideration.

As to treatment.—The preparation of the patient is essential to satisfactory results. Any means of completely unloading the small intestine is satisfactory—the object being to reach the worm by means of some anthelmintic.

I usually keep the patient under treatment for 24 hours—allow them to take a glass of milk for dinner—at about 2 p. m. give them 2 to 4 grains calomel, at 4 p. m. repeat the calomel. Allow them to drink water and a cup of coffee or tea for supper. At 9 p. m. give dose of salts or a seidlitz powder. At 5 a. m. take from 15 to 20 grains of betanaphthol in powder followed by 1-2 or 1 glass of water, at 7 repeat the betanaphthol. At 11 a. m. give a seidlitz powder or dose of salts. At 12 m. give milk and allow them to gradually resume their former diet.

The first 150 cases were treated with thymol, but the danger of the drug and its intolerance by many, led me to try something else. My results from betanaphthol have been absolutely satisfactory.

Instructions are always given that no alcoholic stimulants be used or any oils given.

A second or third treatment is rarely necessary. As the parasite lives only a few years in the intestine and a few do no serious damage—provided only a few remain and the sufferer improves—it is unwise to force them to submit to several treatments. If in two months they have not improved satisfactorily it would be well to investigate and if wise treat them again.

Tonics containing iron and strychnine were given to every other one of the first 100 treated. The progress was no more satisfactory than those who took nothing, so I have discarded after treatment only to advise as to the best articles of diet.

As repeated infections are quite common it is well to warn them of that danger. For this purpose I copy the instructions given by the Porto Rican Commission, which are—"Have a privy in your house. Do not defecate on the surface of the ground, but in the privy. Do not walk barefooted so that you may avoid contracting (grounditch) mazamorra in your feet. Wear shoes and you will never suffer from anemia."

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Just preceding the meeting of the American Medical Association, the American Medical Editors' Association will hold its annual session at the Auditorium, Chicago, on May 30th and June 1st. An interesting programme has been prepared. Medical editors not members of the Association, are invited to attend.

## A CAUSE OF SCROTAL HAEMATOCELE.\*

BY WHATLEY W. BATTEY, JR., M. D., ASSISTANT PROFESSOR, ANATOMY AND CLINICAL SURGERY, MEDICAL DEPARTMENT,  
UNIVERSITY OF GEORGIA.

The tunica vaginalis testis is the location of fluid accumulation produced by itself the lining membrane possessing that property, or by injury of the testicle there being a gradual outpouring into its cavity, further gonorrhoeal inflammation of epididymis syphilis and new growths act likewise. This hydrocele fluid may become discolored being in part due to its age, becoming dark yellow or brown. The gradual accumulation of this fluid does not produce symptoms alarming to patient, until he actually has pain and marked discomfort. When such a condition presents itself he then seeks relief, not always to the physician who is competent to make a diagnosis and suggest appropriate treatment, but to the druggist who at a glance makes a diagnosis of hernia; gives him a suspensory or applies a truss, and leaves the sufferer in as deplorable a condition as before increasing the liability to complications. Imagine a patient with a small hydrocele and varicocele harnessed up in a truss. The direct effect being not only uncomfortable, but adding "fuel to the flame," so to speak, by the pressure of truss against spermatic cord as it emerges from external ring, thus interfering with venous return circulation, and constantly favoring increased varicosities. The pressure produced within tunica vaginalis testis is equal on all sides and as compression of brain is produced, according to some authorities by a rupture of small twigs of blood vessels due to cerebral fluid being set in motion, so will fluid collections in scrotum under influence of traumatism act upon contents of scrotum producing a rupture of circulatory apparatus, provided that varicosities exist, or a simple exudation of serum as the direct effect of impaction, constituting the condition known as haematocele. Among other causes may be enumerated the gradual thickening of tunica vaginalis, and lastly repeated punctures of hydrocele.

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\*Read before the Georgia Medical Association, Fitzgerald, April 15-16-17, 1908.

## SYMPTOMS.

The chief symptoms are pain, swelling of scrotum, blood extravasation.

## DIAGNOSIS.

This is not always easy. The history of the case will give important diagnostic data. This condition may be confounded with hydrocele and hernia. The important diagnostic points in favor of each are as follows:

*Hydrocele.*

Gradual increase in size. Translucency, presence of fluctuation. Pyriform in appearance. Closure of external ring. Absence of impulse upon coughing. Non-reducibility. Absence of inflammation or pain.

*Hernia.*

Doughy feel of scrotum. Impulse upon coughing at external ring. Enlargement of external ring. Possibility of reduction. Presence of marked discomfort. Occasional tympany in other than epiplocele.

*Haematocoele.*

Presence of ecchymosis. History of traumatism. Absence of indications of strangulation. History of the previous existing hydrocele.

To show how important a factor traumatism is in the production of this trouble, I can best do so by reporting a case in point.

Mr. G., a carpenter, age 48, noticed two years ago, a swelling of right side of scrotum. This was accompanied by dragging sensation in testicle, partially incapacitating him from work. He applied for aid at a drug store, and he was given a neatly fitting truss, the druggist making a diagnosis of hernia. This truss was worn constantly for two years. On November 19th, 1907, while at work lifting lumber, in an attempt to stoop, the patient had sharp pain in right side of scrotum, which became more intense, and he was sent home, being unable to resume his duties. I saw him the following day. Upon examination of scrotum noted the following condition: Right scrotum very much enlarged and ecchymotic, owing to extravasated blood. There was swelling in the inguinal region just to the outside of external ring, which was painful upon pressure, resembling hernial protrusion. With the tumor in inguinal region, and epi-

largement of scrotum, and the history of patient having worn a truss, I at once concluded that the case was one of incarcerated hernia, and probably strangulated. The general condition of patient was good. Bowels had not been moved since the day before, but abdomen was soft and not painful. There was no nausea or vomiting. I advised an operation, which advice was accepted. Under ether narcosis, made an incision over tumor in inguinal region down to sac. Upon opening sac expecting to liberate intestine or omentum, I was surprised to find accumulated serosanguinous fluid and blood clots, the sac communicating with scrotum and not with peritoneal cavity. Upon further exploration found rupture of a varicose vein of cord, the hemorrhage from same having been arrested by pressure within sac. Cavity of tunica vaginalis was thoroughly cleansed out and same closed by suture above and Volkman operation done on scrotum. Serosanguinous fluid drained away for ten days, when incision finally healed, despite efforts to keep it open. Patient left hospital with slight swelling of tunica vaginalis testis with the direction to return and have scrotum operated upon later, for hydrocele under cocaine anaesthesia, using aspiration method.

This case proves beyond a doubt, that we can add to the list of causes of haematocele, rupture of a varicocele and that rupture is more likely to occur in the presence of a hydrocele where the effect of traumatism, owing to pressure from hydrocele, would be greater; that the application of trusses by druggists to patients who do not suffer with hernia should meet with our condemnation.

*Report of a Case of Ingestion of Open Safety Pin by a Child Two Years of Age, Subsequently Passed by Bowels Without Symptoms. By W. W. Battey, Jr., M. D.*

I wish to report this case to show how quickly foreign bodies pass from stomach into bowel, and to show how we may be misled notwithstanding most perfect skiagraphic charts, and further the absence of pain during passage of foreign body.

W. H., age two and one-half years, while mother was applying a napkin, grabbed safety pin from mother's dress, the same having been placed there while napkin had been previously removed; placing same in mouth, quickly swallowed it. The mother made an attempt to get pin from mouth of child, but

efforts were fruitless. The child cried and was strangled considerably as pin passed down the oesophagus. The pin was ingested with circular spring part of pin passing down first. I saw the child fifteen minutes after ingestion. The mother was positive that the child had swallowed pin, but to look at the child one would think that she was mistaken. There was no pain over stomach upon palpation. Water was taken and swallowed without difficulty. I advised a skiagraphic examination of stomach, oesophagus and intestinal tract, which was made by Miss Dendy.

Child was put upon farinaceous foods with directions to watch him carefully for any symptoms of pain or other trouble.

The skiagraph showed nothing in the oesophagus, stomach or intestinal tract. I was inclined to believe that the mother was mistaken. On second morning following ingestion I was phoned that the child had passed the pin.

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## PROPHYLAXIS AND TREATMENT OF TYPHOID FEVER.\*

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BY JOHN B. WOODVILLE, M. D., FAYETTE, W. VA.

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When we consider the wide geographical distribution of typhoid fever, its endemic prevalence in many localities and frequent epidemic outbreaks with destruction of life and damage to business in the communities affected, the importance of the problem of prophylaxis is forced upon us, and we realize the truth of the old saying, "an ounce of prevention is worth a pound of cure."

With the rapid advances in medical science of recent years, especially along the line of bacteriology, the question of prevention of some of the most formidable diseases is no longer in its incipency but is an accomplished fact. Yellow fever and malaria, the scourges of the South, are rapidly being eradicated with the destruction of the mosquito. But the causative agent of typhoid fever, the bacillus of Eberth, not being dependent upon the body of a host for existence, but being capable of living and some-

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\*Read before the Layette County (W. Va.) Medical Association, May 5, 1908.

times multiplying in earth, in cesspools, in drinking water, also on fruit and vegetables and other articles of human diet even in ice, its destruction *en masse* is impossible and the question of prophylaxis narrows down to the tracing of the source of infection in a given case and the prevention of its spread in the community. **As we are not likely to become aware of the presence of the typhoid bacillus prior to the development of a case in our midst, our duties towards prophylaxis begin upon the diagnosis of the first case in the neighborhood.** If the bacillus can be found in the water supply, of course the use of that water must be prohibited; or if it is the only source of supply for the family or neighborhood, the water must be boiled before being used. Not only is this precaution necessary for the drinking water, but all water used for household purposes whether for bathing, washing dishes, floors, windows, etc., if procured from an infected source must first be boiled.

Of the utmost importance is the immediate removal from the room and thorough disinfection of all discharges from the patient—feces, urine and sputum. The best and safest means of disposing of these excreta is by burning, but when this is impossible, various chemical antiseptics are at our disposal. Chemical disinfection of typhoid excreta is surrounded by difficulties and is uncertain—the best antiseptics requiring from one to twenty-four hours of continuous contact with the infective material in order to render it free from danger. The best agents for this purpose mentioned in the order of their efficiency, are lime, bichloride of mercury and carbolic acid. Formaldehyde is also used but it is doubtful whether it has any advantages over lime as a disinfectant for typhoid excreta.

Whatever agent is used, it must be thoroughly mixed with the stools by stirring with a stick, breaking up all solid lumps, the stick being immediately burned.

Lime in the form of solution of the chloride when mixed with typhoid discharges requires one hour to render them innocuous. Bichloride of mercury requires six hours and carbolic acid twenty-four. Chloride of lime being the most effective and the cheapest will likely remain the disinfectant of choice with the country practitioner.

Six ounces of the powdered chloride to a gallon of water

makes the proper strength. The discharges after being disinfected unless burned, should be thrown into trenches four feet deep and covered with earth.

The bed pan and all vessels and dishes used by the patient should be washed in boiling water. The person of the patient must receive strict attention as regards cleanliness and the clothing and bed linen should be boiled before being sent to the laundry or given to the washer woman. This precaution should be always observed since it is a well known fact that washer women may and sometimes do, contract typhoid fever as a result of washing infected clothing; and being careless in the disposal of the wash-water, might throw it where it would drain into a spring or well and thereby cause an epidemic.

Physician and nurse must wash the hands with hot water and soap, then in 1-1,000 bicloride solution after ministering to the patient. The thermometer should be subjected to the same process.

Purification of infected water, inspection of sewerage and drains while important in the prophylaxis of typhoid fever, fall within the domain of the public health authorities rather than the private physician.

#### TREATMENT.

There are some members of the medical profession who take a pessimistic view of the treatment of typhoid fever, believing that we have no drugs capable of exerting a favorable influence over this disease, but that all that is required is a good nurse. On the other hand, special forms of treatment have been brought forward from time to time with extravagant claims in their behalf.

Let us not go to the extreme of optimism on the one hand, nor should we be pessimists, like Osler, who casts a shadow over therapeutic progress by the assertion that "we pour drugs of which we know little, into bodies of which we know less." But rather should we take the middle ground in our battle with this disease, using intelligently the means at our command, ever bearing in mind the limitations as well as the possibilities of medicine.

Of the utmost importance in the treatment of typhoid fever, is absolute rest in bed from the first prodromal symptoms, if we see the case so early, until convalescence is well established. It is a matter of common observation that persons stricken with



typhoid fever who are compelled to make a journey or undergo other physical exertion while ill, are almost certain to develop a severe attack. To this factor, I believe is due in great measure the high mortality of typhoid fever among patients sent to hospitals from private practice.

Fresh air is as essential in the successful treatment of typhoid fever as it is in tuberculosis. Statistics show a lower rate of mortality among cases treated in tents and open shanties than in private residences and hospitals, and this difference can be due to no other cause than fresh air.

The diet must be fluid from the beginning of the illness until there has been no elevation of the evening temperature for at least a week. Milk is conceded by most authorities to be the best diet in typhoid, though it may be supplemented with animal broths or raw egg albumen in water especially in those patients who find difficulty in digesting milk, vomiting it or passing it in curds in the stools. Boiling the milk for a few days or giving a dose of lime water or a little pepsin with it will often aid in its digestion in these cases.

Hydrotherapy as advocated by Brand, with its modifications, also the internal use of antiseptics are methods of treatment to which have been ascribed specific virtue. While they cannot be regarded as specifics there is no doubt of their great value as adjuncts in the general management of this disease.

The length of this paper will not permit a detailed description of the Brand treatment by means of cold baths, with which we are familiar, and which, by the way, is utterly impracticable in private practice in the country where we are often denied the luxury of a wash-nay and a bath-tug is a thing unknown. We can get the good effects of the cold bath, such as reduction of temperature, diminished frequency and increased force of the pulse, sedation of the nervous system and induction of sleep, by means of tepid sponging with brisk friction, without the shock and work and exertion of the patient incident to the dub bath or cold pack.

Many drugs have been used in the treatment of typhoid fever with varying degrees of success. My individual experience convinces me that those of greatest benefit are quinine, calomel, turpentine, alcohol and strychnia, and the mineral acids, my preference of which is the aromatic sulphuric.

So firmly convinced am I of the efficiency of quinine, that I would be loath to take charge of a case of typhoid fever without this drug; and were I restricted to the use of one remedy, quinine would be my choice. One has but to observe the effect of withdrawal of this remedy in a case doing well—watch the temperature go up, the tongue become brown and cracked, the abdomen tympanitic and nervous symptoms develop, all going to show that the bacilli infesting the intestinal tract are rapidly elaborating toxins which being absorbed into the blood are overpowering the vital powers of the patient—to be convinced of the value of quinine.

I do not indorse the enormous doses advocated by Liebermeister, nor do I believe that it should be given at all for its *antipyretic* effect, but it should be given throughout the course of the disease in dosage sufficient to keep the system under its influence and maintain its antidotal effect upon the toxins that are being absorbed into the blood.

If quinine can kill the malarial parasite in the blood, which it does in so weak a dilution as 1 to 20,000, why would it not have some neutralizing effect upon toxins elaborated by other forms of bacteria?

Too much stress cannot be placed upon the importance of elimination. All of the organs should be kept active. The bowels to carry off the rapidly multiplying bacteria and fermenting refuse of food; the skin, kidneys and lymphatic glands to deal with the toxins which have been already absorbed, and the liver to pour out nature's antiseptic, the bile, which passing down the intestinal tract exerts its antifermentative and bacteriolytic influence throughout its course. All of these indications are met by calomel. Being a laxative, an efficient diuretic, and having a selective action upon the liver and excrementitious intestinal glands, it carries along smoothly the process of elimination, and the result of *faulty* elimination—tympanites, weak heart action, dry, brown and cracked tongue, prostration and nervous irritation as shown by subsultus tendinum, carphologia and other evidences of the typhoid state are held in abeyance.

At least one or two free bowel movements should be had in twenty-four hours. If the bowels become too active, the *astringent* effect of aromatic sulphuric acid, aided if necessary by bismuth of sulphorcarboliote of zinc will hold them within bounds,

so that we have to contend with neither constipation nor diarrhoea.

At the beginning of the illness a good calomel purge with podophylin should be given until the bowels are thoroughly emptied, the calomel should be continued in dosage of one to two grains a day supplemented by other laxatives as occasion demands. Should tympanites develop, turpentine internally and locally is the best remedy.

I do not approve of the promiscuous use of stimulants, but if in spite of our best efforts the case sinks into the typhoid state, stimulants are demanded, and of these alcohol and strychnine hold the first rank. Their use should not be postponed until symptoms of adguamia are well developed, but should be given upon the first signs of warning—dry tongue, irregular, intermittent or dicrotic pulse, and indistinct first sound of the heart.

Intestinal hemorrhage should be treated by cold to the abdomen, absolute rest and the administration of adrenalin and acetate of lead and opium with the subcutaneous use of normal salt solution if the hemorrhage has been profuse.

If perforation occur, the only hope lies in surgery, and Keen says the operation is hopeless unless done within twenty-four hours.

A seemingly trivial matter, but really of importance, is attention to the mouth during the course of the disease. If sordes is allowed to accumulate and decompose upon the teeth, it furnishes a favorable nidus for the growth of various bacteria which may enter the system through the tonsils or be swallowed or inspired and give rise to grave complications. A saturated solution of barocic acid, or one of the analogues of listerine makes an excellent wash for cleansing the mouth and teeth.

The management of convalescence requires strict supervision of the diet. No change in the diet should be allowed until the third or fourth day after the temperature has returned to normal, when a soft boiled egg or a little milk toast may be given. The condition of the pulse and appearance of the tongue should guide us as well as the temperature in forming an opinion as to the proper time to allow an increased diet and to let the patient leave the bed.

# EDITORIALS

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The Medical Journal Company has purchased Dr. George Brown's interest in the Journal-Record of Medicine. With this disposal of his stock, Dr. Brown resigns as business manager of the Journal-Record, and extends to each subscriber and advertiser his thanks for favors shown and hopes for a continuation of their valued support of the Journal-Record of Medicine.

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## THE ANTIVIVISECTIONIST.

There are a few consistent opponents of vivisection, the best illustration of whom is to be found in that large mass of the people of India who do their best to avoid killing even a poisonous insect. Yet these, in spite of all precautions, destroy daily the lives of millions of minute beings. In the West there are great numbers of apparently normal persons who are not nearly so considerate of life in general as are these East Indians, and who yet raise their voices in fierce vituperation against the scientific vivisector who deals out less pain in a year than most hunters in a day, and indeed than a large proportion of stock dealers in a minute. We doctors are libelled as heartless wretches by ignorant or prejudiced upholders of the sanctity of the guinea pig in contradistinction to the cheapness of the human. We are supposed to care nothing for the sufferings of any creature

besides man. We know that to the medical mind vivisection is a painful necessity and not out of accord with the methods whereby nature or the God of nature enlarges the gradual evolution of life. All good has come along a road which might be called evil, and was certainly imperfect. When we understand better, perhaps we will find that evil is nothing but one side of good. In any case a study of nature's processes makes it perfectly evident that to raise a huge outcry against a properly regulated system of vivisection having in view the annihilation of disease, pain, and even death in men and animals alike is to exhibit to the world a mind deficient in judgment and insight. The antiviviselector, not the scientific viviselector, it is who deserves to be placarded as cruel and heartless as well as weak. But the missionary spirit of the opponent of vivisection is worthy of cultivation if turned into a useful channel. And the wonder is, if his love for the animal world is as acute as he would have us believe, that our cities continue to be infernos of cruelty. A walk through their streets sickens and disgusts. If the physiologist behaved to his necessary sacrifices on the holy altar of science as some dealers and owners of stock behave out of mere lack of sympathy and laziness to their helpless victims he would be worthy of all the worst that has ever been said of him. We daily pass crate upon crate of chickens dying for a drop of water and trampling upon one another in the stifling air of a burning pavement, and horses and mules whose every step is an agony being mercilessly urged by the whips of drivers merrily whistling while their beasts would fain lie down and die. Is not there something of the savage in us still, that such things should be permitted? And is not there a place for the medical profession in the ranks of the society for the prevention of cruelty to animals? Should not every doctor as a matter of course, belong to that society?

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#### THE CRAWFORD W. LONG MONUMENT.

It is particularly fitting that a monument be erected by the medical profession of Georgia to one of her most distinguished citizens, Crawford W. Long, the discoverer of ether anesthesia.

With this purpose in view the Athens Woman's Club has

undertaken the collection of funds for the erection of this memorial and it is earnestly desired that every physician in the state make a prompt contribution and thereby assist in honoring a notable member of the profession—the discoverer of one of the most useful of anesthetics.

It is a sad commentary and a reflection upon Georgia that Long should have received greater honors in other countries than he has in his own State. A prompt contribution and hearty co-operation of the physicians of this State will enable the Woman's Club to erect a monument in Athens, the home of this distinguished citizen, and thus in a measure may we neutralize our past neglect and delinquency. The United States has honored the name of Dr. Long by awarding him a place in the Hall of Fame in Washington, D. C., but the niche is yet unfilled.

Let every physician consider this a personal matter and one in which his pride is at stake. A worthy monument will do much to dispel further disputes as to who had priority in the discovery of ether and will leave a record for the enlightenment of coming generations.

Dr. Hardman has agreed to erect a monument to Long at the original home of Long and the place in which ether was first administered.

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### COMMENCEMENT OF THE ATLANTA SCHOOL OF MEDICINE.

The Third Annual Commencement of the Atlanta School of Medicine was held April 22nd, in the Grand Opera House.

The conferring of degrees was by Ex-Gov. W. J. Northen, president of the board of trustees, and the annual address by Dr. John G. Olmstead. The report of conditions at the college, rendered by Dr. George H. Noble, showed an enrollment of 274 students—an increase of 18 per cent. over that of last year. The graduates numbered 49.

Seven seniors were the recipients of certificates of distinction. They are as follows: W. C. Hays, W. C. Tipton, C. D. Bannister, O. O. Fanning, R. A. Verier, S. E. Clinard, I. Willis.

Those receiving the degree Doctor of Medicine, were:

From Georgia: W. D. Aderhold, C. D. Bannister, J. H. Bark-

well, B. S. Bomar, J. C. Bramblett, J. B. Brown, A. B. Buñs, O. B. Bush, H. O. Byrd (president of class), S. E. Clinard, Y. R. Coleman, W. J. Creel, W. L. Ethridge, J. K. Hall, W. C. Hays, F. B. Hill, W. H. Houston, W. D. Howard, N. B. Hutchison, W. A. N. Jones, A. Lazenby, W. H. Lewis, J. E. Morrison, G. E. Neal, C. E. New, G. S. Sellman, W. C. Tipton, T. G. Turk, H. G. Wallace, H. H. H. Ward, C. W. White, L. W. Wiggins, R. P. Orton, H. C. Stovall, T. L. Vineyard. From Florida: D. H. Adams, O. O. Fannings; A. S. Applewhite, Mississippi; M. Medlin, Mississippi; G. L. Webb, Mississippi; E. L. Patterson, South Carolina; R. A. Verdier, South Carolina; O. C. Grunitz, Tennessee; J. A. Saliba, Turkey.

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#### COMMENCEMENT EXERCISES OF THE ATLANTA COLLEGE OF PHYSICIANS AND SURGEONS.

The Atlanta College of Physicians and Surgeons awarded diplomas to thirty-three physicians and fifty-five dentists, April 24.

The report of Dr. W. S. Elkin, dean of the medical department, showed that during the year just closed, there were 224 students in the medical department, 180 in the dental department and 121 in the pharmaceutical department.

Certificates of proficiency were presented to the following young physicians:

Dr. G. L. Bush, of Georgia; Dr. T. C. Hodge, of Georgia; Dr. Shields, of Georgia, and Dr. N. J. Newman, of Georgia.

The graduates were:

J. O. Baldwin, J. H. Baxter, W. L. Beauchamp, L. H. Bishop, B. S. Branham, G. L. Bush, J. L. Cheshire, G. L. Echols, D. B. Edwards, W. E. Fulmer, J. A. Green, G. O. Gunter, T. C. Hodge, W. C. Howell, C. T. Key, F. V. Meriwether, S. R. Methvin, W. C. Miles, S. E. McCotter, N. J. Newson, A. R. Parrott, J. E. Pressly, J. L. Shepard, H. F. Shields, J. T. Smith, R. J. Spier, R. M. Stephenson, C. C. Stockard, Jr., and L. R. Weeks.

## PURE MILK, CREAM AND ICE CREAM.

The Atlanta Board of Health is now preparing to enforce an ordinance recently passed and undoubtedly is a wise one and should receive the hearty support of the medical profession. The law provides that:

"All vehicles used for hauling or distributing milk or cream must be kept neat and clean, and in good repair, and must not be used for hauling manure, slops or anything else of an objectionable nature, and must be provided with a covered top of canvass or other material which will protect all vessels containing milk of cream from the rays of the sun.

"Cream sold, or offered, or kept for sale as such must contain at least 20 per cent butter fats, and must not contain any foreign substances or coloring matter, and must not contain more than 500,000 bacteria per cubic centimeter.

"Ice cream sold or kept for sale must contain at least 10 per cent. butter fats for fruit ice cream, and 12 per cent. for plain ice cream."

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## OBJECT TO AUTOMOBILE LAW.

A number of prominent physicians of Atlanta are making a strenuous fight against the passage of Councilman Grant's vehicle ordinance which provides that no vehicles be allowed to stop in front of buildings in the congested district. It further requires that an attendant must be left with such vehicles; also that vehicles must stop when a car in front comes to a stand still to let off passengers.

There were present at the meeting of the committee to pass upon the ordinance, Dr. James B. Baird, Dr. Floyd W. McRae, Dr. William B. Armstrong, Dr. Cyrus W. Strickler, Dr. C. E. Murphey and Dr. B. E. Pearce.

Such a law will impose a great hardship upon the physicians who use automobiles in their practice. The doctor is as a rule a careful chauffeur; in fact this fact is so well recognized in certain large cities that on account of the urgency of his mission the physician is not subject to the usual speed limit.



## DR. KNOPF ON CONSUMPTION.

Dr. S. A. Knopf, of New York, delivered an exceedingly interesting and instructive public lecture at the Grand Opera House, April 26th, under the auspices of the Atlanta Sanitary and Tuberculosis Prevention Society.

The importance of preventing tuberculosis is only known to physicians and a few of the laity and such lectures by men who have given the question so much thought and study must eventually be of great value in lessening the great white plague, or as Dr. Todd aptly calls it in the South "the great black plague."

There are few bits of medical literature that have received wider circulation and more appreciation than has Dr. Knopf's prize essay on the prevention of tuberculosis. The amount of good it has done cannot be easily estimated.

Dr. Knopf also appeared before the Fulton County Medical society and made address to the physicians of Atlanta. His thorough familiarity with all phases of the subject and his attractive manner of presenting it make him a most interesting speaker.

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ANNUAL REPORT OF THE BUREAU OF HEALTH OF  
THE PHILIPPINE ISLANDS.

The report of the Bureau of Health of the Philippines for the year ended June 30, 1907, by Victor G. Heiser, M. D. Director of Health, demonstrates that the sanitary reforms which have been persistently carried out during the past few years are bringing concrete and substantial results which more than justify their continuation. There has not been a single case of plague in the Islands and not one death from small pox in the city of Manila.

Since the method of combatting plague has been based upon the theory that its eradication could be accomplished by isolating the sick and destroying plague-infected rats, the efforts of the Bureau have met with complete success.

Four hundred and three deaths were reported as caused by beriberi. It is thought that this disease is more common among

persons who eat only Philippine rice which is not husked until shortly before using, owing to the mold which soon renders it unfit for consumption, than among persons who use imported China or India rice, which has been husked for a year or more before being used.

A special effort is now being made to combat tuberculosis. During the past year in Manila one-sixth of the deaths were due to this cause. A bulletin has been issued on tuberculosis which discusses the symptoms and signs of the disease, and urges the importance of early diagnosis, especial stress being placed upon the importance of its prevention.

Typhoid fever is becoming more prevalent and seems to be obtaining a firmer foothold in the Philippines that it has had in the past.

Attention is called to the low per cent. of insanity in the Islands. It is one-fifth of that of Great Britain showing that it is far less prevalent than elsewhere. The report says that these figures are particularly significant in view of the fact that consanguineous marriages are common in the Philippines, since such marriages have been ascribed as one of the principle causes of mental derangement. It will be interesting to note in the future whether the increased nervous tension which naturally accompanies a higher civilization will be conducive to an increase in the proportion of insanity.

Owing to an increase in the number of deaths from amoebic dysentery, arrangements have been made to have instructions as to prophylaxis taught in the public schools.

By segregating the lepers at the Culion leper colony it is thought that the Islands may soon be freed from this disease. In collecting lepers from the Islands of Samar and Leyte for the purpose of transferring them to the Culion colony, it was found that errors had been made in the diagnosis and that many of the cases were tropical ulcers, phagadenas, or syphilis. The *spirochaeta pallida* was demonstrated in many of the patients.

Particularly satisfactory is the report on small pox. In the provinces where heretofore there have been more than 6,000 deaths annually from this one disease alone, not a single case of small pox has been reported since vaccination was completed more than a year ago.

## DEATH OF DR. WIMBERLY.

Particularly sad are the details of the death of Dr. Warren Wimberly who was nearly drowned six miles south of Jeffersonville, April 26. While on horseback on his way to visit a patient he tried to ford a stream much swollen by the recent rains. After a desperate struggle he finally reached the opposite bank, but after considerable exposure died while being taken home by some friends in a buggy. Dr. Wimberly was well known in Macon and was related to many of Georgia's well known citizens.

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A committee has been appointed by the Wisconsin State Medical Society for the protection of its members against malpractice suits. The purpose is to obtain necessary funds, and to employ the best legal talent for the defense of any member of the society needing such services.

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## BOOK REVIEWS

## THE AMERICAN POCKET MEDICAL DICTIONARY.—

Edited by W L. Newman Dorland, M. D., editor "The American Illustrated Medical Dictionary. Fifth Revised Edition. 32mo of 574 pages. Philadelphia and London: W. B. Saunders Company, 1906. Flexible Morocco, gold edges, \$1.00 net; thumb indexed, \$1.25 net.

W. B. Saunders Company, Philadelphia and London.

This handy little volume contains some thirty thousand medical terms with brief, but clear and adequate definitions, with a considerable amount of matter in tabular form. The vocabulary is well selected and up to date.

**A TEXT- BOOK OF PATHOLOGY.**—By Alfred Stengel, M. D., Professor of Clinical Medicine in the University of Pennsylvania. Fifth Revised Edition. Octavo of 977 pages, with 399 text-illustrations, many in colors, and 7 full-page colored plates Philadelphia and London; W. B. Sanders Company, 1906. Cloth, \$5.00 net; Half Horocco, \$6.00 net.

W. B. Saunders Company, Philadelphia and London.

The favorable reception of previous editions has convinced the author that his purpose of supplying a moderate-sized book on clinical pathology has found favor with the profession. In this edition the section dealing with General Pathology has been most extensively revised, several of the important chapters having been practically rewritten. A practical addition is an Appendix treating of the technic of pathologic methods, giving the most important methods at present in use. The work will be found to present the latest knowledge on Pathology.

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**NERVOUS AND MENTAL DISEASES.**—For the Student and Practitioner. By Charles S. Potts, M. D., Professor of Neurology in the Medico Chirurgical College of Philadelphia, Neurologist to the Philadelphia Hospital, etc. Second Revised Edition, enlarged, illustrated, with 133 engravings and 9 plates. Lea & Febiger Publishers, Philadelphia, Pa.

This book comprises 570 pages and presents in rather a concise manner the essential facts of neurology and well fulfills the design of the author in presenting the subject *practically*. We think it advisable that students should begin their study of the various branches of medicine by the use of rather elementary works than in the bewildering large volumes written by specialists and for specialists or practitioners of experience.

Potts has covered the subject in a systematic manner and has incorporated the recent advances in this field of medicine.

The illustrations are good and the binding of the same excellent which characterizes the publications of Lea & Febiger.

**GYNECOLOGY AND ABDOMINAL SURGERY.**—In two large octavos. Edited by Howard A. Kelly, M. D., Professor of Gynecologic Surgery at Johns Hopkins University; and Charles P. Noble, M. D., Clinical professor of Gynecology at the Woman's Medical College, Philadelphia. Large octavo volume of 851 pages, with 405 original illustrations by Mr. Hermann Becker and Mr. Max Brodel. Philadelphia and London: W. B. Saunders Company, 1907. Per volume, Cloth, \$8.00 net; Half Morocco, \$9.50 net.

W. B. Saunders Company, Philadelphia and London.

In view of the intimate association of gynecology with abdominal surgery the editors have combined these two important subjects in one work. For this reason the work is doubly valuable, for not only the gynecologist and general practitioner will find it an exhaustive treatise, but the surgeon also will find here the latest technic of the various abdominal operations. It possesses a number of valuable features not to be found in any other publication covering the same fields. It contains a chapter upon the bacteriology and one upon the pathology of gynecology, dealing fully with the scientific basis of gynecology. In no other work can this information, prepared by specialists, be found as separate chapters. There is a large chapter devoted entirely to medical gynecology, written especially for the physician engaged in general practice. Heretofore the genral practitioner was compelled to search through an entire work in order to obtain the information desired. This work presents it all in one chapter. Abdominal surgery proper, as distinct from gynecology, is fully treated. The chapter on Complications of operations will be of great service to every operator, as it considers in detail every complication following operations which can occur. There are also elaborate chapters devoted to Operations during pregnancy, operations before puberty and conservative operations upon the appendages—subjects usually treated of only in monographs. Special attention has been given to modern technic and illustrations of the very highest order have been used to make clear the various steps of the operations. Indeed the six hundred and fifty original illustrations are truly magnificent, being the work of Mr. Hermann Becker, Mr. Max Brodel, and other eminent artists of the Johns Hopkins Hospital.

**A TEXT-BOOK OF EMBRYOLOGY.**—By John C. Heisler, M. D., Professor of Anatomy in the Medico-Chirurgical College of Philadelphia. Third Revised Edition. Octavo volume of 432 pages, with 212 illustrations, 32 of them in colors. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$3.00 net; Half Morocco, \$4.25 net. W. B. Saunders Company, Philadelphia and London.

The new edition of this work, just issued, represents all the latest advances recently made in the science of embryology. Many portions have been entirely rewritten and a great deal of new and important matter added. A number of new illustrations have also been introduced and will prove most valuable. The previous editions of this work filled a gap most admirably, and this new edition will undoubtedly prove even more valuable. Heisler's Embryology has become a standard work.

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**CHEMICAL PATHOLOGY.**—Being a Discussion of General Pathology from the Standpoint of the Chemical Processes Involved. By H. Gideon Wells, Ph., D., M. D., Assistant Professor of Pathology in the University of Chicago and in Rush Medical College, Chicago. Octavo of 549 pages. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$3.25 net.

W. B. Saunders Company, Philadelphia and London.

As the chemistry of disease processes is the foundation of practical treatment, the subject is of the utmost importance to the practitioner and the clinical investigator. Dr. Wells here presents the latest work systematically considering the subject of general pathology from the standpoint of the chemical processes involved. It is written for the physician, for those engaged in research in pathology and physiologic chemistry, and for the medical student. In the introductory chapter are discussed the chemistry and physics of the animal cell, giving the essential facts of the theories of the composition of proteids, and of ionization, diffusion, osmotic pressure, etc., and the relation of these facts to cellular activities. Special chapters are devoted to Diabetes and to Uric-acid Metabolism and Gout.

## NEWS AND NOTES

The German government has prohibited the future use of salicylic acid as a preservative.

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Since the prohibition of the use of goat's milk, Malta fever has decreased in a remarkable manner in the island of Malta.

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Unusually severe outbreaks of small pox are reported from Japan, especially in Tokio and Yokohama.

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According to the report of the Pennsylvania Railroad Employee's Relief Fund for the twenty-five years of its existence, \$18,000,000 in benefits has been paid out.

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Miss Florence Nightingale, who won world-wide fame by her work in the camps and among the military hospitals during the Crimean war, has just been added to its roll of Freeman by the city of London.

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During the month of March there were 198 deaths in the Canal Zone, including the cities of Panama and Colon, in a population of 114,920, corresponding to an annual death rate of 20.67 in 1,000 of population.

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Dr. John C. Hemmeter, urges that the monument to be erected to Dr. Walter Reed in Washington, include Drs. Lazear and Carroll, who were also members of the yellow fever commission.

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The annual meeting of the Georgia State Sociological Society was held at Atlanta, in the Piedmont assembly hall, Monday and Tuesday, the 4th and 5th of May.

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Dr. J. McF. Gaston and wife have been appointed missionaries to North China by the Foreign Mission Board of the South. Dr. Gaston goes as a medical missionary and will assume charge of the Tyzzar Hospital at Laichon Tu, in the province of Shantung. Dr. Gaston has been practicing medicine in Atlanta for 15 years and has been prominently connected with the Missionary Medical School.

The measure proposed in Virginia to exempt physicians from paying a license fee has been defeated.

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"The Southern Medical Journal" is the name of a new journal which is to be published at an early date in Nashville, Tenn.

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A class of thirty-five were graduated from the Medical Department of the University of Georgia, at Augusta, May 1.

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The Maryland house and senate have passed the so-called anti-Christian Science bill which prohibits all Eddyists from practicing medicine unless they have passed the regular examination, or eschew the acceptance of fees.

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Mulford & Co., have issued some interesting "Working Bulletins" on vaccine therapy, Wright's opsonic theory and its practical application. The supplement to Bulletin No. 1, furnishes further information on the dosage and method of administration of bacterial vaccines. Bulletin No. 2, is on tuberculin and tuberculin therapy.

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The Georgia Pharmaceutical Association held its meeting in Thomasville, May 19 and 20. J. D. Persse, of Savannah, is president of the Association; L. S. Brigham, of Columbus, is vice president; B. S. Persons, of Macon, and T. B. Rice, Greensboro, vice presidents; J. T. Shuptrine, of Savannah, treasurer, and Max Morris, of Macon, secretary.

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The California Anti-Narcotic law goes into effect July 1, 1908, and partially prohibits the sale of narcotics without a physician's prescription and states that no poison shall be sold to any person less than eighteen years of age.

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The fourth annual meeting of this association will be held at the Auditorium Hotel, Chicago, on June 5th and 6th. An extensive program has been arranged, and the meeting promises to be both interesting and profitable.



At the annual meeting of the American Surgical Association, which was held recently in Richmond, Va., the following officers were elected for the ensuing year: President, Dr. C. B. G. Napcrede, of Ann Arbor, Mich.; vice presidents, Dr. A. P. Gerster, of New York, and Dr. Leonard Freeman, of Denver; treasurer, Dr. Charles A. Powers, of Denver; secretary, Dr. Robert G. Leconte, of Philadelphia. The meeting in 1909 will be held in Philadelphia.

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Dr. Rudolph Matas, 2255 St. Charles avenue, New Orleans, La., is compiling the statistics of operations for the cure of aneurism by his method of intrasaccular suture. (endoaneurismorrhaphy), and will be obliged to all surgeons who have had experience with this operation for a brief report of their cases.

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The freedom of the City of London has been conferred on Miss Florence Nightingale. At her request the illuminated resolution presenting her with the freedom of the city, was closed in an oaken instead of, according to the ancient custom, golden casket, and a check for 100 guineas was devoted for the furtherance of those objects to which she has given her whole life.

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The preesident of the German Colonial Society, Duke Johann Albrecht zu Mecklenburg, announces that a prize of \$1,500 will be awarded to any one who can suggest a means by which cattle can be protected against the bites of the tsetse flies while they are being taken through a region infested with these flies.

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The alumni of the Medical Department of the Tulane University of Louisiana propose to give a Stanford E. Chaille jubilee on May 19 and 20, to celebrate the completion of the fiftieth year of his service as dean of the medical department. Professor Chaille retires from the faculty and deanship at the end of the current year. It is proposed to establish a Chaille Memorial Fund from the alumni and friends of the Tulane University, the funds obtained to be used for a dormitory for medical students and the revenue derived to be used for the support of a chair of physiology or hygiene, to be named after Dr. Chaille. It is hoped that a subscription of \$15,000 or \$20,000 will be made for this purpose.

## TO HONOR DR. CHAILLE.

We note with pleasure the plan of the Alumni of the Medical Department of Tulane University to celebrate the fiftieth year of teaching service of Professor Chaille. The celebration is to take place on May 19 and 20, 1908 in the form of a jubilee.

It is further proposed that a fund be created to preserve the memory of Dr. Chaille and his highly appreciated services to the institution. The Alumni and friends of Dr. Chaille are requested to send their contributions to Dr. Isadore, secretary and treasurer of the Chaille Memorial Fund, P. O. Box 778, New Orleans.

We believe there is no man in the South to whom greater honor is due than to Dr. Chaille and his remarkable service at Tulane.

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If a patient persists in running evening temperatures which cannot be accounted for after a thorough physical examination and blood examination, one should place the patient on increasing doses of the iodids, for the fever may be due to an old syphilitic infection.—American Journal of Surgery.

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In cases of suspected fracture of the skull, percussion-auscultation will be found a valuable procedure where all the other signs and symptoms have been negative. The procedure is the following: The forehead is repeatedly tapped sharply in the median line with the middle finger, the stethoscope being moved from one point to another from before backward. If a fracture be present, a cracked-pot sound is elicited just beyond it. The corresponding part of the head on the other side should be auscultated to eliminate possible error.—American Journal of Surgery.

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The United States Civil Service Commission announces an examination on July 1, 1908, to secure eligibles from which to make certification to fill a vacancy in the position of technical assistant, Division of Pharmacology, Mygienic Laboratory, Public Health and Marine-Hospital Service, at \$150 per month, and vacancies requiring similar qualifications as they may occur in any branch of the service

Persistent, remittent fever after an acute infection of the knee joint is usually due to a systemic invasion. Such cases are best treated by laying the joint wide open (Mayo operation).—American Journal of Surgery.

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REGULAR MEETING, FULTON COUNTY MEDICAL  
SOCIETY, MAY 7, 1908.

EDITED BY R. R. DALLY, M. D.

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DR. STIRLING IN CHAIR.

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Dr. J. H. Johns read a paper upon Ingrowing Toenail and operation for same. He described a modification of the usual operations wherein he made a wider flap at the base of the nail giving clearer view of the matrix and parts to be removed and insuring completion of just what the operator desired to accomplish. His cases under this method have all been successful.

Dr. Armstrong discussed the paper favorably saying he had seen Dr. Johns operate and had accepted the surgical technique as of great value.

Dr. Armstrong exhibited a kidney showing extensive multilocular cystic degeneration. It was removed from a negro who had suffered many symptoms of diseased kidney, but who had been passing 18 ounces of urine a day. The exploratory operation showed the left kidney to be so greatly diseased that those present believed it could be of no value and they advised removal.

After operation there was anuria followed by the discharge of about 15 ounces and again succeeded by anuria and uremia of which patient died. No postmortem was permitted, so the condition of the other kidney could not be known.

Dr. Strickler remarked that many English surgeons were now making their exploratory incisions in the abdomen and thus having opportunity to examine both kidneys before removing one. He also pointed out that Morris had drained some of these cystic kidneys with at least temporary advantage.

# **The Southern Sanitarium**

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Austell Building                      829-30 Candler Building

ATLANTA, GA.

Dr. Kime related a case of infected kidney that was by some surgeons, suspected of being enlarged gall bladder. He made several careful urine examinations, segregating the specimens till he was satisfied that he had pus from the right and urine from the left.

He then operated in the usual region and successfully removed the right kidney. The woman recovered. He believes this is better procedure than making the abdominal incision first and then having to subject the patient to the further strain of the lumbar operation.

Dr. Gaillard spoke in favor of segregation of the specimens.

Dr. Hodgson reported a case of broncho pneumonia beginning 36 hours after birth. The labor was slow and he suspects the child may have breathed in some infectious material during delivery.

At the onset the respirations were very rapid—over a hundred—and the cause was sought in the heavy vitiated air of the room. The child was placed between two open windows and the respirations dropped. Once after that the family allowed the air to get bad, fearing cold, and there was greatly excited breathing. Treatment was continued with fresh air constantly blowing across bed and child recovered.

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At the annual meeting of the Washington Osteopathic Association, held in Seattle, a candidate for governor was nominated, the association claiming that this was the only one of the various candidates who would give osteopathy a square deal. The association is said to be prepared to expend funds in its treasury to work against any candidate who is known to favor legislation against osteopathy, and to aid in legislation favorable to their cult.

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A large, slowly healing superficial ulcer of the leg may be due to a thrombosis of one of the small vessels leading to that part. Of course, syphilitic etiology must first be ruled out.—American Journal of Surgery.

# HYDROLEINE

An emulsion of cod-liver oil after a modification of the formula and process devised by H. C. Bartlett, Ph. D., F. C. S., and G. Overend Drewry, M. D., M. R. C. S., London, England.

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**R. R. Division Point, in Wyoming,**

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## MEDICAL ITEMS

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**CYSTITIS.**—It should not be forgotten how prominently a condition of hyperacidity of the urine figures as an etiological factor in the ordinary case of acute cystitis. Proof of this is found in the readiness with which such cases yield to Alkalithia. This is the alkaline treatment in a form which permits of the alkalies being pushed to the point of alkalinizing the secretions without disturbing the stomach as with the use of the plain alkalies.

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### COMPARATIVE POTENCY OF HYOSCINE AND SCOPOLAMINE HYDROBROMIDE IN REFRACTION WORK: EVIDENCE AS TO UNMISTAK- ABLE NON-IDENTITY.

Dr. Wendell Reber, of Philadelphia contributes an interesting article upon this subject in *The Journal of the American Medical Association* for April 25. His paper was read in the Section on Ophthalmology of the American Medical Association at its Atlantic City meeting in June, 1907. For some unexplainable reason this article, which bears so strongly upon the controversy concerning the alleged identity of hyoscine and scopolamine, has been withheld from publication for eleven months. This is of peculiar interest, inasmuch as the editor of the Association Journal during this period has been asserting and reasserting most vociferously through the columns of that journal that these two alkaloids are both chemically and pharmacodynamically identical. Dr. Reber's conclusions, which were based upon careful experimental work made upon human beings, are diametrically opposed to the assertions of Dr. C. H. Simmons, Dr. H. C. Wood, Jr., and others, in *The Journal of the American Medical Association* and its "anvil chorus."

Dr. Reber was led to these experiments by an experience reported in *The American Journal of Pharmacy* in 1899. At that time he found that when one drop of a 1-10 per cent. solution of hyoscine hydrobromide was used in the right eye, and one drop

# Journal-Record of Medicine

Successor to Atlanta Medical and Surgical Journal, Established 1855.  
and Southern Medical Record, Established 1870.

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EDGAR PAULIN, M. D., Opsonic Medicine.  
R. R. DALY, M. D., Medical Society.  
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E. G. BALLENGER, M. D., Diseases of the Genito Urinary Organs.

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## THE DOCTOR AND HIS RELATION TO SOCIETY.\*

BY J. C. OLMSTED, M. D., ATLANTA, GA.

Ladies and Gentlemen, Doctors of the Graduating Class: In the countries of the old world, where the order of Knighthood exists, when one is admitted to this order, his sovereign touches him on the shoulder with the flat of a sword, and he is said to receive the "accolade," which confers upon him the rank of "Sir Knight." On this occasion, gentlemen of the graduating class, your alma mater in presenting you with your well earned diplomas, confers the "accolade," which admits you, and consecrates you to the service of a profession, nobler, and more ancient by far, than any order of Knighthood. A profession whose beneficent history reaches so far back in the annals of our race, that it is

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\*Annual address at the Commencement of the Atlanta School of Medicine, April 22, 1908.



lost in tradition, amidst the shadows; and night, of a remote antiquity. You have indeed a right to be proud of your diploma as "Doctor in Medicine." It comes as the reward of laborious years of diligent study under the direction of accomplished, experienced, and painstaking teachers, who have instructed you in those various branches of science, upon whose broad and deep foundations your profession rests, founded as upon a rock. You now stand upon the threshold of your career, and this is truly your "commencement," for you are now to go forth, to apply the scientific principles which you have received, to that most difficult Art, the practice of Medicine. I shall on this occasion, speak as briefly as I can, on the Doctor in his relations to society; using this term in its broad sense of community, and I may here say with Burns,

"But how the subject theme may gang, let time and chance determine;

"Perhaps it may turn out a song, perhaps turn out a sermon."

I will not promise to stick closely to my text, as good preachers are said to do; I may turn up in unexpected places, but so does our friend the Doctor, and hence I am sure to be logical! I confidently assume in the premises, that the Doctor is as interesting as he is an important character in the community. The presence here to night, of this large audience, is one guarantee of the truth of this statement. Woman deigns to grace the occasion with her presence, and to smile encouragement, auspicate success, on your entrance into the noblest of professions; not excepting perhaps, the Christian ministry; for in the sacredness of its duties and obligations, in devotion to duty, and in large self-sacrifice, it is in my humble opinion, "second to none!"

Have you my younger brothers, who aspire to be ministers in this temple of medicine, reflected upon the serious responsibilities which you invite? Have you considered the lofty aims, the self-sacrifice for the good of others, the purity of mind and heart, which should characterize him who enters here? Without these, we will never be worthy of that title of highest honor, which in ages past was bestowed upon members of our profession, when they were called "the Divine" or "God-like men." To be worthy of the noble character which is here implied, should indeed be the high aim of us all; and no lower standard should suffice. Of the profession of medicine it has been truly said,

that it is "the noblest of professions, and the meanest of trades." That the "trade" spirit is abroad in certain quarters of the profession, is not to be denied; and is only an admission that the medical profession, like everything else human, has been contaminated by the dollar chasing craze of this age; but not yet have "the money changers" taken entire possession of the "sacred temple of Aesculapius!" There yet remains a goodly host of its disciples, with whom its primitive doctrines, and traditions, are yet vital principles, and perennial truths; such as these, uphold their noble art, in all its primal beauty, and redeem it from the withering blight, of mere self-seeking gain. I am not urging an impossible romantic altruism, that the doctor has a right to expect compensation for his work, is not in antagonism to the foregoing; nor does this deny the claims of true charity; but he too must live, and even St. Paul declared that "they who preach the Gospel, should live of the Gospel." Yes, the doctor, and the preacher must live, although some people in their treatment of both, seem to have forgotten this important truth! The doctor may incidentally grow rich by his profession; few of us, are exposed to this danger! But this will ever be a secondary consideration, with the true hearted physician. Never will he prostitute his noble art, to this ignoble aim, and end. His wealth is for other than this; it is a "treasure" of good deeds, noble efforts, lofty aspirations, in an impregnable character, which "neither moth" of greedy gain, "nor rust" of neglected worth, can "corrupt;" nor "thieves," of time serving policies, "break through, and steal!"

The practice of medicine is as truly an art, as painting, music, literature, etc. Like these arts, it has of course certain scientific principles, and aspects; but it is more of an art, than that exact science, which some would claim it to be. And so in the main, it must ever be from the nature of the conditions and circumstances, by which it is limited, and under which its processes must be conducted. These being variable, it is hence impossible to limit it, within the "hard and fast rules," of a "fixed science." He is the master of this art, who best understands the peculiar conditions, and features of the case before him, and hence is best prepared to meet its requirements; just as the painter mixes his colors, and blends them to express the light, and shadows, and objects, in the particular landscape before him, even so

the physician, considers the particular features of the individual case before him, and adapts his remedies, to meet its especial requirements. Among the laity generally the impression prevails, that diseases are treated according to their names: Such and such a thing "is good for pneumonia" or "typhoid fever," etc. I have seen this error of treating diseases by their names, committed by some physicians, that important factor, the individual with the disease, being apparently ignored! With the laity this impression is I believe fostered by the gorgeous rhetoric of the multitudinous "patent medicines," so dear to the public heart. But dare I impugn the magic virtues of "Peruna," "Paines Celery Compound," "Carter's Little Liver Pills" and "Brown's Iron Bitters?" These, and many others, all "vouched for," mostly by venerable clergymen, with affidavit faces, or benevolent, grand, motherly-looking old ladies, to question whose veracity, would almost seem impossible! The physician who treats all cases of the same disease, in exactly the same manner, will commit as egregious blunders as would the painter, who should apply the same blending of colors, in the same manner, without regard to the varying effects of light, and shade, and perspective, etc., in different landscapes. In the case of the painter, a "botch of a picture" is the result, in that of the doctor, a grave may be filled. The public often think it strange, to hear physicians speak of the fascination which the study and practice of their art possesses for them. Yet by the true physician, it cannot be imagined, that the arts of music, poetry, painting, etc., afford an enjoyment more keen than his. And surely the doctor needs this enthusiasm, for in the words of the old song, he often has "a hard road to travel," with days of trial, and often nights "devoid of ease," and it may be at times ingratitude as the reward of his patient, well directed efforts, he must find his consolation and happiness in the higher realms of his noble calling, in its intellectual triumphs, and the consciousness of duty well performed. The doctor in his relations to society, should have a many sided mind, that is he should be a man of liberal culture, and informed on many and varied subjects; his opinion being not infrequently called for, on subjects of general interest to society. He should be capable of adapting himself to that "all sorts and conditions of men," high or low, rich or poor, learned or unlearned, with whom he is brought in contact.

Think of it! To what a variety of characters, good, bad, and indifferent, of minds weak, strong or mediocre, sane, partially sane, and insane, does the doctor have to adapt himself? He must listen with a grave face, and respectful bearing to the oft repeated "tale of woe" of the hypochondriac, whose ruddy cheek and general good health, belie his utterly impossible symptoms. or patiently investigate "the most peculiar symptoms doctor," of the imaginative lady, who is sure that she has a cancer! He must attempt to live through his many and varied experiences with the hysterical lady, whom perhaps 'wealth and idleness, allied to a naturally peevish disposition, have combined to form this plague of the doctor's life. He must preserve his equanimity of temper, when under fire of the old "Colonel," who, furious from the pain of "suppressed gout," and unsuppressed ill-temper, is disposed to hold the doctor, and not the wine he has drunk, personally responsible for his condition. From giving a "plain talk" to some in need of that discipline, he must approach the frail, nervous, and timid woman, whose life is to be counted by days, it may be hours. Not only caring for their physical ailments, but as their trusted friend, and wise councillor, he bears in his bosom, the secret sorrows of many a household. To the doctor the community looks, for those directions, and well planned measures, by which its health is preserved, and pestilence is warded off. And yet, how often in his efforts, to have wise laws enacted for the protection of the community from contagious, and infectious diseases, is he thwarted by the ignorance, or culpable indifference of selfish politicians bent only upon their schemes of personal aggrandizement! These so-called "Solons" (Save the mark!) whose often foolish performances in the legislature, cumber the statute books with worthless "laws," forgotten as soon as passed, and promptly buried in well merited oblivion! And yet the doctor was seeking to protect the community, by efforts to eliminate disease, and hence in large measure, to eliminate himself, by preventing, rather than curing disease!

Is there any other calling, or profession on earth, with a financial interest connected with it, whose highest aim is to limit the sphere of its operations, and personal interests? But occasionally there comes along, some shrewd, witty, and cynical, so-called "philosopher," chiefly engaged in making money, and

airing a loose morality, and who in a brilliant "lecture" gravely informs the public, that "the doctors are parasites!"

This of a profession, which not to speak of its many achievements, in relieving suffering humanity in other fields of disease, has practically abolished that hideous disease "small pox," where it's advice has been taken; which has done much to circumscribe the ravages of cholera, and is now engaged in a hopeful struggle, with the "plague" of the East, and Tuberculosis, the world over; and which last, but not least, to us of the South, has banished from our shores, that dread scourge "yellow fever," which used to depopulate cities, paralyze their commerce, fill their cemeteries with its victims, and send the panic-stricken inhabitants, flying for protection to other sections of the country; poor, distracted wanderers, often treated as most unwelcome guests! Think of the suffering, and death, not to mention the immense financial loss, which was involved in a visitation of "yellow fever!" All of this has now passed away, like some hideous vision of the night. By what, and whom, has this change been accomplished? By the doctors, those heroic men, who in discovering the cause of the diffusion of this disease, risked their lives, and in some instances lost them, in personal experiments upon themselves, to prove the source of contagion! Nor should we forget, that army of the dead of our profession, who lost their lives in fighting this disease, and who lie in the cemeteries of Savannah, Mobile, New Orleans, Vicksburg, Granada, Holly Springs, Chattanooga, and Memphis, with its "Doctor's Street," as they call that portion of the cemetery where they rest! This is a list of "battle fields," where fell many who left happy homes, in healthy localities, to aid their over-worked brethren in the cause of humanity, and who returned no more! Their claims to grateful remembrance and immortal fame, forgotten, perhaps, in the lapse of years; voiced it may be only, by the complaining night wind, as it murmurs through the trees that shadow their humble patriot graves! Surely for such, if for any, should the "monument of enduring bronze, and everlasting marble," uplift its stately shaft, to greet the earliest light of the morning, and reflect the splendors of parting day, in a golden glow of immortal memories! As I think of our profession in its high service to humanity, I love to associate the doctor, with that beautiful

legend, which comes to us from the far, and mystic East, in which the poet tells us how—

"Abou Ben Adhem, may his tribe increase!  
"Awoke one night, from a deep dream of peace;  
"And saw within the moonlight of his room,  
"Making it rich, and like a lily in bloom,  
"An angel, writing in a book of gold.  
"Exceeding peace, had made Ben Adhem bold;  
"And to the presence in the room he said,  
"What writest thou?" The vision raised its head,  
"And with a look, made of all sweet accord,  
"Answered, "the names of those that love the Lord."  
"And is mine one?" Said Abou. "Nay, not so"  
"Replied the angel, Abou spoke more low,  
But cheerly still, and said "I pray thee then  
Write me as one that loves his fellow men!"  
"The angel wrote and vanished, the next night  
It came again, with a great wakening light,  
"And showed the names, whom love of God had blessed,  
And lo! Ben Adhem's name led all the rest!"

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## A CASUAL REVIEW OF THE WORK ON THE APPENDIX.\*

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We find records of incisions for the purpose of draining abscesses in the right iliac fossa dating back as far as beginning of the Christian era, being about the year 50 B. C. The first recorded case of diseases of the appendix was reported by Mestivier in the year 1759, who incised and drained an abscess in the right iliac fossa in a man of 45 years of age. The patient died a few days later and an autopsy revealed a badly diseased appendix, and when opened, it was found to contain a rusty pin. From the time Mestivier reported his case up to the year 1824, six other cases of abscess in the right iliac fossa were reported,

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\* Read before Ocmulgee Medical Society, April 21, also Fulton County Medical Society, April 23, 1908.

where autopsy revealed advance disease, and the presence of foreign bodies in the appendix.

All of the reports, covering a period of 65 years, up to 1824 referred to the diseased condition found in the appendix, but considered it secondary to some lesion originating in the colon. In 1824 Louyer Villermay published an article in which he described inflammations of the appendix as definite disease. In 1827 Melier, another Frenchman, published a paper on the subject even more striking in detail than his colleague, Louyer Villermay, calling particular attention to the fact, that at autopsies, the pathology of the appendix had been much overlooked, and predicted the possibilities of surgery for its relief.

The accurate descriptions of Louyer Villermay and the well founded theories of Melier were not used by their contemporaries in the profession, because Dupuytren, the leading surgeon of his day, was too narrow to realize the importance of this great opportunity, and remained an exponent of the thought of his time, which referred to the colon, the origin of all right iliac inflammatory processes. The German surgeons in applying the name Perityphlitis to all inflammations of the right iliac fossa, both encouraged and confirmed the erroneous opinion which has in some quarters hardly been obliterated in our own day.

The interpretation of the symptoms and pathological findings of inflammations in the right iliac fossa had kept pace with the rapid evolution of surgery, and were now recognized and known to be characteristic of disease of the vermiform appendix.

In 1884 Kronlein, of Germany, made a diagnosis of perforation of the appendix, and did the first operation for its removal. The wound was closed up without drainage and the patient died three days later. Two years afterwards, in 1886, Hall, of New York, did the first successful operation for the removal of the appendix with the recovery of his patient. Until this time dispute and contention was still rife as to the origin of abscesses in the right fossa, and not until Reginald Fitz, of Boston, in the same year gave to the surgical world his epoch making paper, clearly defining relationship between disease of the colon and appendix, did the subject which had been buried under a mass of inco-ordinate facts and unstable theories, become cleared of all obscurity, and established upon a scientific basis.

In this notable paper of his, we note the following dictum.

"It is the duty of every physician to be mindful that for all practical purposes, Perityphilitis, Perityphlitic Tumors, Perityphlitic Abscesses, mean inflammation of the vermiform appendix." And it is to Fitz we give the distinction of having named the condition Appendicitis, he preferring the term rather than having it known as Fitz' disease. After the atmosphere had been cleared by Fitz' paper, it was not long before our aggressive surgeons realized the misdirection of their former efforts, and were hasty in their attempts to handle this important condition, along the lines suggested by modern surgical pathology.

In 1889 McBurney gave a powerful stimulus to the surgical treatment of Appendicitis by demonstrating the feasibility of doing the operation without destroying the continuity of the abdominal wall. Since that time the McBurney inter-muscular operation has been the standard—others simulate, but none excel.

From this casual review of the literature on the subject of Appendicitis, we readily see that the aggressive surgery of the appendix as it is practiced today, is only 24 years old, and though first suggested by a Frenchman, first executed by a German, all praise be to our American surgeons, who have brought the work up to its present high standard of perfection.

The anatomy of the appendix is very interesting, and at times most perplexing, for its anatomical position is not fixed; in fact there is no portion of the abdominal cavity where the appendix may not be found. These anomalies of position are due first, to an abnormally long Meso-appendix; second, to an arrest of foetal development. A long appendix with a long Meso-appendix may extend across the media line of the body into the left iliac fossa, or, extend upwards or inwards among the coils of the intestine, and it has been found firmly attached to the anterior abdominal wall. When the cecum and appendix are found out by the right lower quadrant, this condition is due to an incomplete rotation of the gut during the process of foetal development, likewise, the cases of retrocaecal and retropetritoneal appendicitis, are due to faulty rotation. The average length of the appendix is 3 1-2 inches, but it has been found as long as 9 inches and as short as 3-4 of an inch. Its lumen or cavity is as variable as its length. It is found to be partially or totally occluded in at least one-fourth of all specimens examined. This variability of the organ as to position, size and structure, are considered by the evolutionist as a



sign of degeneracy in the process, which is undergoing a gradual obliteration in the higher animals. Alimentation has an important bearing on the development of the cecum in many of the higher animals. Herbivorous animals have an enormously developed cecum, whereas, in carnivorous animals it is found small, and sometimes wanting. In man, apes, and many of the rodents where the food is midway between that of the Herbivorous and Carnivorous types, a retrograde development of the cecum is found, giving rise to a long worm-like projection from the base of the cecum which is known as the vermiform appendix. This retrogression is probably due to changes in the character of food which has taken place during the history of the species. Our foremost students in comparative anatomy believe that the appendix is destined for further reduction in size and ultimate elimination.

What is the etiology of inflammation of this little troublesome worm-like organ? Naturally, we look to the various micro-organisms as being the exciting factors, chief among which is the colon bacillus. In connection with the exciting causes the predisposing must not be lost sight of. It must be borne in mind that the appendix is a vestigial organ undergoing an evolutionary and retrograde metamorphosis, and it is recognized that organs of this structure are especially liable and susceptible to inflammation. The scarcity of its blood supply renders it a poor combatant of infection. The appendicular artery, a branch of the ilio-colic, lying between the folds of the meso-appendix is very prone to circulatory disturbances from many conditions either physiological or pathological that increase intra-abdominal pressure. Acquired or congenital narrowing of its lumen precludes complete emptying of the organ, and fecal stagnation easily results. It is surrounded by a firm unyielding peritoneal coat, embracing structures composed of soft embryonal elements, so that in an infection we have added compression and tension, which explain the rapidity with which gangrene may take place. With all these added predisposing anatomical factors, we should not wonder that appendicitis is the most frequent of all abdominal surgical diseases. The records of reported cases show that the disease is more frequent between the ages of ten and thirty years, during that period of life when lymphoid tissue is most abundant. Erdmann in his recent writings on Appendicitis, in children, published in the New York Medical Record reports, 100 cases vary-

ing in age from 21 months to 15 years, and in this series he was able to demonstrate foreign bodies in 41 of the 100 appendices removed. It is thought to be more frequent among men than women, because of the better blood supply in the female, the appendix sometimes receiving a branch from the ovarian artery. Digestive disturbances, constitutional disorders, movable kidney, foreign bodies, and trauma, have all been written about and discussed as possible predisposing agents. However numerous the predisposing cause, we should ever bear in mind that the essential for the production of an inflammation is the presence of someone or more of the pyogenic micro-organisms.

Pathologically, we find all varieties of lesion from the mild catarrhal to the fulminating and gangrenous types.

The early symptoms of the disease are not indicative of what the ultimate outcome may be. We have nothing to tell us which case is going to do badly and which one is going to do well. Pain and tenderness are the symptoms that are most often met with. Temperature elevation, and acceleration of the pulse are not indicators of the severity. Vomiting by some is thought to be a forerunner of Peritonitis. Rigidity of the right rectus muscles is usually present and most significant. Constipation is the rule, though diarrhea may exist. With all the symptoms of an acute inflammation in the appendix, without one single symptom to tell us whether the condition will go on to resolution or become gangrenous or perforate, what are we to advise our patients to do when consulted? Worcester, of Waltham, Mass., in a paper published in 1892, answers this question most emphatically in the following words: "Appendicitis is an inflammation of a useless organ, dangerously situated. At the beginning of an attack it is not possible to determine whether it will prove of the harmless or of the dangerous type. The diagnosis is easy in comparison with the task of diagnosticating the seat of any acute inflammation. At the beginning of an attack the excision of the appendix is an easy and perfectly safe operation. If so treated, all complications and all subsequent attacks are avoided. In view of the results already obtained by following this treatment, no other treatment is worthy of consideration." From the time of his writings to the present day no one has been able to give more truthful and life saving advice covering this condition. Ask the surgeons the cause of mortality in their oper-

ations for appendicitis, and they will invariably tell you complications of delay. There is only one logical treatment for the disease that cannot be criticised, and that is, early excision of the organ as soon as the diagnosis is made, provided there are no heart, kidney or pulmonary contra-indications. What we wish to accomplish in the treatment of this condition is not to save one-half of our patients, nor four out of five, but all of them—and in order to do this, no chances of hopeful expectation must be taken, nor delays advised.

We must admit that 80 per cent. of all cases will recover under the so-called medical treatment, but the remaining twenty per cent. will do badly, and it is this twenty per cent. that we are striving to save. Of the 80 per cent. that respond to medical measures, a large number will at some future date have a return of the trouble, and this time may not yield to former treatment. Until the art of prognosis is established upon a more scientific plane, we had better be over-cautious in giving an opinion as to the ultimate outcome of any acute attack of appendicitis, for, in cases where we least expect it, we oftentimes find a pocket of pus or an appendix already gangrenous, and the patient having given us physical signs of neither. Research in the examination of the blood in these conditions has given to us some light upon the resistance of our patients, the fight they are making against the infection, and the degree of severity of the pathological process. I know of no disease where such discrepancies exist between physical signs and pathological findings as we often see in appendicitis.

In the simple catarrhal types of the disease, many surgeons give reports of mortality of less than half of one per cent. where several hundred cases have been operated upon successively. So gratifying are the results in the interval cases or in the early beginning of a disease that there was quite a tendency a few years ago to wait and watch for the interval, but since we are growing older in the work, we are likewise becoming wiser. Waiting and watching should not be taught or practiced either in private or public, for perforations occur under our own eyes, and the best clinicians in their endeavor to check spreading infection are confronted with disastrous results. Most surgeons will tell you that they are always worried while watching and waiting on a case of appendicitis not operated upon. Perforation and

spreading infection kills ten times as many patients as inexperienced operators, in the early stages of the disease.

It has been urged that in grave cases abstention will save more lives than operation. Simpson reports thirteen cases of general or extensive Peritonitis, with only one death. Can abstention promise more? Surely nothing can be lost by providing an escape for an inflammatory exudate, thereby reducing the task of the body in taking care of the baccilli and the toxins which they produce. The main principal of the operative treatment in grave cases should be to do the least that would be sufficient to accomplish the object, whether it be to relieve the appendicitis or arrest a beginning of Peritonitis. The work should be done as rapidly as possible, ever mindful of doing the "minimum surgical trauma to accomplish the maximum of surgical safety." This having been done, I contend, will save more lives than similar cases treated along so-called conservative medical lines. As yet I know of no drug that will in any way stay the progress of beginning gangrene, or in the least lessen the accumulation and dissemination of its pathological products.

By the operation we strive to remove the appendix and establish drainage, if necessary. Choice of operation is usually a personal equation of the operator, some preferring McBurney's incision, some Deavers, and others the incision of Kammerer. Not so much is dependent upon the choice of incision as is upon the manipulation of the viscera adjacent to the diseased appendix. Here we should use all care and gentleness, ever careful not to break up adhesion, if pus or other inflammatory exudate be present. The appendix should be isolated, its mesentery securely tied, and its union with the base of cecum brought full in view. Various methods, all good when properly executed, for treating the stump are in vogue. Some ligate the appendix, cut and cauterize the stump and drop back into the abdomen, others after tying off the appendix, cutting it away invaginate the stump in the wall of the cecum and suture the peritoneum over its site; one method proving as satisfactory as the other in the hands of various skilled operators.

If called upon to operate after perforation has taken place, and we are reasonably sure of the presence of pus, Deaver's or Kammerer's incisions will probably find more favor than McBurney's, for they give more room for thorough investigation.

In such cases if we are convinced that the process is thoroughly walled off by adhesions, and the appendix difficult to locate, and if by endeavoring to isolate and separate it from the mesentery or coil of intestine to which it is adherent, we are in immediate danger of breaking down nature's barrier and spreading the contaminating exudate, it is far more advisable to establish thorough drainage in this class of cases and wait for the subsidence of the inflammation, before any attempt is made to remove the offending part. This necessarily means a second operation, but will leave a monument to our effort in the existence of our patient.

Every case where there is an exudate resulting from inflammation in the appendix should have some form of drain. In such a practice, many cases will be drained, that would recover without; but the uncertainty of some cases in which its absence might mean added danger, a second operation, or even death leads me to use it in every case where any doubt exists. Its disadvantages are not more than minor inconveniences. A slight delay in union, a transient pain on removal. In this operation, as in all others done in the abdominal cavity, the wound should be closed in layers, careful of leaving no dead space for the formation of clots, which so frequently are responsible for the failure of primary union.

Wonderful and marvelously progressive has been the science of medicine during the past quarter of a century. In the day of our own recollections we have either seen or heard of patients dying in a very few hours from an acute cramp colic, inflammation of the bowels, an acute typhoid fever, an acute congestive chill, and idiopathic peritonitis. Postmortem findings and pathology on these subjects, teach us that such conditions do not exist per se, but that in the appendix we find the destructive lesion. Rapidly we are having such misconceptions and erroneous diagnosis forever erased from the instructive pages of our modern medical literature. The operative mortality in appendicitis is going to be reduced, just with the same degree of rapidity as our patients learn to have the work done during the hours of election and not waiting until the time that necessity demands.

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#### DISCUSSION.

*Dr. F. W. McRae.*—Enthusiastic as I am for surgery, ever ready to wield the scalpel that promises quick and sure relief. I cannot unqualifiedly endorse Dr. Jones' position, i. e., "That appendicitis, in the absence of complications, is always a surgical disease properly treated only by immediate operation, whether the diagnosis be made early or late." To me such a position seems illogical in the face of the inherent tendency of the disease towards recovering in eighty to ninety per cent. of first attacks. A disease of such protean types seen under such varying conditions, must admit of the intelligent application of medical and surgical principles.

What a relief it would be to me to know that my duty to every victim of appendicitis had been fully performed when I had recommended immediate operation by a competent surgeon! Alas, for my peace of mind, I cannot do so! I feel compelled to deal with each case of appendicitis on its merits. I have lain awake o' nights both on account of advising and on account of not advising immediate operation. I am a most earnest advocate of early diagnosis and immediate operation in all cases seen within the first 24 hours, practically all seen within the first 48 hours of the progress of the disease.

Many mild attacks of appendicitis will have practically subsided within 48 hours. I should hesitate about advising immediate operation in all such cases. I see some cases of appendicitis between the third and tenth days of the disease where the pathology is definitely localized, and well walled off as evidenced by the physical signs and general symptoms, where I advise delay and

the Ochsner, starvation, plan of treatment. Such cases should be seen often and observed closely by a competent surgeon. It is far safer to drain an adherent, virtually extra-peritoneal, abscess on the eighth or tenth day than to expose the peritoneum to the virulent infection lurking in or about a very intensely inflamed appendix on the fourth or fifth day of the progress of the disease. I have had abscess cases brought to me from a distance, and found on arrival that the large tumor present before leaving home, had disappeared, the abscess having emptied through the bowels. I take it, no prudent surgeon would advise immediate operation under such conditions.

These are some of the exceptional conditions under which I do not advise immediate operation. I earnestly advocate immediate operation in all cases of spreading or general peritonitis except those practically moribund, removing the offending appendix with the greatest possible dispatch and the least possible handling and trauma, large properly placed drains through counter punctures, if need be, the Fowler position in bed and the Murphy normal salt solution procto-clysis.

My views on the treatment of appendicitis are based upon an experience comprising 528 appendectomies, with a total mortality including all deaths due to complications of every kind, of eighteen. I have done 398 interval operations of various types including recurring, chronic relapsing, and cold abscesses, with one death a mortality of partially 1-4 of 1 per cent. I have had two deaths in thirty-four acute cases, early operation, one from a co-existent double septic nephritis operated on at the same time, draining both kidneys. The other from apoplexy in a fat, elderly woman, on the fifth day, apparently from getting out of bed while the nurse was not in attendance. The remaining fifteen deaths were in acute abscess cases, and fulminant or gangrenous appendicitis with spreading or general peritonitis, fifty-three of the former and forty-two of the latter type.

In conclusion, gentlemen, I wish to state that I consider appendicitis first, last and all the time a surgical disease, but in such exceptional instances as those noted above not immediately an operative one.

*Dr. Cyrus Strickler.*—I believe in operating upon all cases of appendicitis. I don't understand why one should hesitate. I have never yet seen a case die from an operation, that would

not certainly have died without it. The earlier the operation, the better chance we have of saving these cases. I believe an operation, at any time, safer than medical treatment.

*F. G. Hodgson.*—I advocate operating upon all cases just as soon as one is absolutely *sure* the patient has appendicitis. Delays are too dangerous, for we can not tell by the symptoms just what is going on in the appendix. If an abscess forms it should be drained at once, for while an occasional abscess ruptures into the bowel, they are more apt to rupture into the peritoneal cavity and cause a general peritonitis. I think many deaths from operation for appendicitis are due to too much manipulation and breaking up of adhesions.

I know of a case entering St. Luke's Hospital, N. Y., which was practically moribund, he was too weak to take an anaesthetic, so an incision was made under cocaine over the appendix and the pus drained out. Another opening was made in the median line and drained. The patient began to improve the next day and made an uneventful recovery. So I think all cases should be given a chance. A simple incision with draining will cause very little shock and will assist nature in getting rid of the toxic materials. If the appendix is readily found, of course it should be removed.

*Dr. E. C. Davis* endorsed Dr. Jones' paper and emphasized the need of operation in all cases not contraindicated by pulmonary, renal or cardiac troubles. He said he was unable to tell what is going on in the abdomen by the external signs. No one knows the point to which the disease has progressed until in bad cases, it is often too late. Therefore there should be careful, judicious operating at once and the conditions met as they present themselves. He feels safer in this way than he does in trying to guess what is occurring in an abdomen.

*Dr. Sellman* asked as an anaesthetist, to be informed of the exact contraindicating conditions. His experience has been that the surgeon has gone ahead anyway, stating that the relief of the abdominal condition was more important than the risk of the contraindicating trouble.

*Dr. James N. Ellis.*—The recognition of surgical intervention as the proper procedure in the treatment of appendicitis, coincides, in date, with the beginning of my professional life. Consequently, with the advent of my first case of appendicitis, a con-



sideration of the then unsettled question of when to operate, was immediately forced upon my attention. I still remember my anxiety in the treatment of this first case, and of those immediately succeeding it; of my indecision as to whether the time for surgical intervention had arrived, and of my subsequent unrest when I left the patient, fearing I was procrastinating, and had allowed the psychological surgical moment to pass.

Happily for my present serenity of mind and, I firmly believe, for the welfare of my patients, this period of perturbation, of uncertainty and of indecision on my part is long since a thing of the past. As a result of a continuously increasing experience and observation, my views on this vexed question have become thoroughly crystalized into a conviction that practically every case of appendicitis demands immediate operation as soon as the nature of the trouble is recognized, and competent surgical intervention can be obtained. The possible exception to this rule would be in the case of practically moribund patients, upon whom the operation, to use an Irishism, amounts to an ante-mortem post-mortem.

Appendicitis is a treacherous disease, and should be dealt with by the surgeon vigorously, aggressively, decisively and promptly. Delay in supposedly convalescing patients is fraught with danger and, often, with disaster. All of us who have had extended experience with appendicitis, and who, in our days of doubt have practiced expectant treatment, have seen such apparently convalescing patients suddenly and unexpectedly develop a general peritonitis, say from the eighth to the twelfth day, and die promptly, with or without surgical intervention. I have frequently operated on an apparently convalescing patient, and found an appendix ballooned to its utmost capacity with pus, and only the thin, serous investment intervening to protect the peritoneal cavity from a virulent, lethal infection.

The question with me now is not whether or when to operate, but what intervention shall I practice in this particular case? This frequently cannot be positively determined until the abdomen has been opened, and the exact pathological condition disclosed. So far as the surgeon is concerned, all cases of appendicitis may be resolved, for practical purposes, into four groups; namely, First, Chronic Appendicitis; Second, Acute Appendicitis, without involvement of adjacent structures; Third, Acute Appendicitis,

with circumscribed abscess; and Fourth, Appendicitis, with diffuse peritonitis.

The technique of operation in groups one and two are practically the same, the McBurney muscle splitting, short incision being generally used to gain access to the cavity.

There is one method of dealing with the stump of the appendix in these cases, which I wish to mention in order to condemn it. I refer to the plan of burying the ligated, infested stump of the appendix by a superimposed purse string Suture of linen or Pagenstecker. The pocket thus made will necessarily become infected in a number of cases. While this does not kill, as the resulting abscess finally discharges into the caecum when the cat-gut ligature gives way, it is responsible for a temperature of 100 degrees or 101 degrees, not infrequently observed as late as the seventh or eighth day after operation by this method.

Operation in groups one and two is admittedly one of the safest and most satisfactory in surgery, and should be almost devoid of mortality.

In the third group, where the infection has extended to the neighboring structures, with the formation of a circumscribed abscess, immediate operation is, in my opinion, just as imperative, whether the attack has lasted twelve hours or twelve days, but the procedure is varied according to the individual findings.

The abdominal incision is made over the most prominent part of the tumour, and if the abscess wall is found adhering to the underlying peritoneum, the pus is evacuated without entering the general cavity; the appendix removed, if readily accessible, but left, if difficult of access, and drainage established. If the abscess is not adherent to the anterior abdominal wall, the surrounding mass is carefully isolated by gauze pads, effectually protecting the general cavity; the pus carefully sought for and gently removed by sponging; the appendix found and removed; drainage instituted; the abdomen closed and the patient put to bed in the exaggerated Fowler position.

It is especially in the fourth group, namely those with diffuse peritonitis, in which delay in operating and the institution of the Ochsner method of treatment is being quite extensively and enthusiastically advocated by both surgeons and physicians. But surely, if the surgeon confines himself to making an outlet, or outlets from the peritoneal cavity for the escape of the accum-

ulated purulent material, and provides for the temporary continuance of drainage, he has greatly facilitated the recovery of such a patient. It is after the establishment of such drainage that the inauguration of the Ochsner method of gastric lavage, prohibition of food by the mouth and rectal alimentation become life-saving measures, and find their logical applicability.

The Ochsner method, combined with the continuous saline enema of Murphy, and the semi-erect posture of Fowler, applied as a post-operative procedure, is of incalculable value. As a substitute for immediate operation in appendicitis, it is deceitful and misleading, and, I believe, has proven a curse, by offering a seemingly safe course for timid patients, and procrastinating, vacillating, temporizing, undecided surgeons.

*Dr. R. H. Donaldson.*—Practically every man doing abdominal surgery has his own ideas about when to operate in appendicitis, and my own personal opinion has changed several times, especially during my first few years of practice. I began with the idea of advising operation in all cases whenever seen. After some little while I came to the conclusion that each case should be treated on its individual merits and judgment used with regard to recommending operation. For the last four years I have recommended operation in all cases, whether seen early or late, and although I am sure that a great many cases would have recovered from the attack without operation, I believe that it is safer, more scientific, and will have a very satisfactory effect on one's mortality rate. It eliminates the excessive worry over each case, absolutely safeguards waiting too long, which is very important, because this organ is very like the human heart as described by David in being "deceitful above all things and desperately wicked."

I would possibly still be on the fence in regard to some exceptional cases, were it not for the fact that our technique has so improved that with rapid, successful work, very little handling, a conservative amount of drainage and the most excellent after-treatment (to which several gentlemen have referred tonight), we can usually handle the situation, whatever little what pathological condition may be present.

I most heartily endorse everything in Dr. Jones' excellent paper.

*Dr. W. S. Goldsmith.*—The discussion of this paper has assumed a wide latitude, going from the treatment of simple catar-

rhial appendicitis to perforative peritonitis. I am in entire accord with the views expressed relative to the treatment of the extreme types of the disease; that is, I favor early operation and the treatment of peritonitis cases by the Fowler position and the Murphy instillation. The importance and value of this latter treatment admits of no argument. I shall now repeat the assertion, made upon this floor two or three years ago relative to cases of three to five days duration, which are in an active abscess formation period, where the temperature is running from 101 to 103 and pulse 110 to 115, that this is the stage where under no circumstances do I operate. I am really surprised at the views taken by the gentlemen discussing this subject tonight, that they would, without reservation, operate on all cases of appendicitis just as soon as seen by them. It is frequently the case that we are called in conclusion four or five days after the onset of the disease, and while at one time in my experience I operated on all of these cases as soon as seen, my mortality was astonishingly high. I am frank in saying that I now believe I have saved patients by not operating at this stage where before I lost them. Nothing has been said about the application of the ice bag and the administration of an occasional small dose of opium at this stage of the disease. Frequently the abscess will drain back through the bowel and for the time being relieve the situation. I admit that this is not the most desirable thing to occur, but it has unquestionably been the means of saving many lives. The sincerity of conviction compels me to repeat that my adherence to the practice as outlined is good surgery.

*Dr. Jones, (Closing).*—I wish to thank those gentlemen who have discussed my paper this evening, for the many valuable points which they have brought out.

I wish I could feel as does Dr. McRae concerning the desperate cases, that it is better to delay than always operate on some of these cases. We have nothing to warrant that the abscesses are not just as likely to rupture into the peritoneal cavity as into some of the hollow viscera. I think the statistics of the larger hospitals show more recoveries now than formerly, largely because operation is done rather than wait and watch. Dr. Westmoreland brought out the fact that the great decrease in mortality in the desperate cases has come from early operation and less medical treatment. As Dr. Strickler said, if these bad cases

die after the operation they would have died without it, and we would feel that all possible had not been done unless we operate.

In making up our statistics, I think it but fair to count these cases that die without the operation on the side of our mortality, provided we have the opportunity to do so and refuse. ...

I am hoping that some prognostic sign may be discovered which will always tell us how to proceed in the treatment of this very important condition, and until then I must remain on the side of those who advocate operation in every case unless some of the contra indications mentioned exist.

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### PYELITIS IN PREGNANCY.\*

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This may be defined as an inflammation of the pelvis of the kidney occurring during pregnancy and may be continued into the puerperium.

Attention was first called to this condition by Chamberlain of this country in the American Journal of Obstetrics for April, 1877. He said that the enlarged uterus caused retention of urine in the kidney, and subsequent inflammation of the pelvis of the kidney. Kruse, of Wurzburg, next drew attention to this condition in 1899. At the French Congress of Surgeons in 1892, Reblaub reported five cases. Vinay and Bonneau in 1893 first noted that the kidney of the right side was the more frequently affected. Dr. Navas, of Lyons, in 1897, asserted that the cause of the inflammation was usually the colon bacillus. Vinay, in 1898, at the Congress of Obstetrics and Gynaecology of Marseilles, re-

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ported eight additional cases and noted that cases may occur as early as the second month of pregnancy; that the cause is usually the *b. coli communis*; and that the prognosis is generally good. Weill, in 1899, said that the infection usually took place through the blood and not by ascending from the bladder. Cragin, in New York has made a careful study of these cases and has reported twenty-three cases in his practice. Many other observers have reported cases and the literature of the subject is quite extensive.

The ureters are subject to the pressure of the enlarged uterus, especially at the point where they enter the brim of the true pelvis. Here the uterus presses them up against the resistant bony wall of the pelvis and dams up the urine in the ureters and pelvis of the kidneys. (In a number of autopsies upon pregnant or recently delivered women the ureters and pelvis of the kidneys have been found in an irregularly dilated condition.) The pressure upon the ureters causes a stasis of urine or uronephrosis. This in turn causes a congestion of the ureter and pelvis of the kidney. So we have a very favorable condition for the development of inflammation. It has been found that this inflammation develops more frequently on the right side. This is because of the oblique position of the uterus due to the rectum being on the left side, and because the long diameter of the fetal head is more frequent in the right oblique diameter of the pelvis subjecting the ureter on the right side to more pressure. It has also been asserted that right handed women sleep more upon the right side, and this would subject the right ureter to more pressure from the heavy uterus.

There are two forms of pyelitis in pregnancy; the one occurring in the early months due to an infection ascending from the bladder and usually of gonorrhoeal origin; the other occurs in the later months, the infection is through the blood and is usually due to the colon bacillus. This paper will deal mainly with this second class of cases.

*Etiology.*—The predisposing causes are: Lowered vitality of the patient; poor hygienic surroundings; alcoholic or venereal excesses; traumatism; calculi in the kidney or ureter. Frequently a history of some preceding gastro-intestinal disturbance can be obtained—this is interesting from the fact that the colon bacillus is the germ usually present in these cases. Any pelvic

deformity or peri-uterine lesion may also be a predisposing factor.

The exciting cause is usually the colon bacillus. We have a "locus minoris resistentia" in the congested and dilated ureter and pelvis and we have an excellent culture medium in the stagnant urine. The mode of infection is through the blood, or hoematogenous. The infection is descending and not ascending, for if a cystitis develops it is secondary and not primary.

These attacks usually come on in the second half of pregnancy, the majority of the cases reported being in the fifth month or later.

This is because the pressure of the uterus upon the ureters is not so marked until the uterus has risen out of the pelvis.

One would suppose that it would be more frequent in primiparae on account of the greater pressure of their abdominal walls, but reports vary; one series of cases showed ten primiparae to four multiparae, another thirteen to eighteen; another seven to three; making a total of thirty primiparae to twenty-five multiparae. The age of the patients varied from 17 to 54 years.

*Pathology.*—Not many of these cases come to autopsy, but there has been found that the ureters and pelvis are irregularly dilated on one or both sides and they contain purulent urine. Microscopically the tissues are congested, ecchymotic, and show small round cell infiltration. The kidney may show inflammatory and suppurative changes, even to destruction of much of the kidney substance.

*Clinically.*—The cases are divided into the sudden or acute, and the insidious or mild. The former begin with an acute pain in one or both kidneys, there is a chill followed by a rapid rise in temperature up to 104 to 105 F., the pulse is rapid, and they may vomit. The pain may radiate down the ureters. There is frequent and painful micturition due to reflex spasm of the bladder; the urine is very cloudy and upon standing shows a large deposit of pus cells. The second or mild form comes on late in pregnancy, the onset is more gradual. They complain of some pain in the kidney region, usually the right; the temperature is not so high and they have less spasm of the bladder. These are the cases that are apt to be overlooked or improperly diagnosed.

*Symptoms.*—Pain is usually the first and most important.

There is a constant dull pain in the lumbar region of one or both sides, which become more acute by paroxysms and may radiate down the course of the ureters. The pain is due to the congestion and tension in the kidneys and is similar to nephritic colic. Complete occlusion of the ureter will make the pain more acute and it may be suddenly relieved, followed by a flow of a large quantity of purulent urine into the bladder.

*Temperature and Pulse.*—There is a mild apyretic form occurring late in pregnancy. The typical cases run a curve which resembles malaria; they have a chill followed by a rapid rise which continues a short time, they have headache, then the temperature falls and the patient perspires freely. The pulse goes up with the fever and may remain 100 or more after the temperature has fallen to normal. Digestive troubles usually precede the attack. There is often a history of diarrhoea or constipation, indigestion, anorexia and coated tongue.

There is a frequent desire to urinate, but only small quantities are passed. There may be sharp pain due to spasmodic contraction of the bladder. A true cystitis may develop late in the disease due to the infection travelling down the ureters. The total quantity of urine varies from day to day, but rarely do we get total anuria due to occlusion of both ureters.

*Physical Signs.*—The kidney of the affected side may be palpable and is always tender to pressure. In very advanced cases there may be a perinephritic oedema visible in the lumbar regions. Rarely can the ureter be palpated per vagina unless the inflammation has extended down to the bladder. The cystoscope will show purulent urine coming from the affected side.

*The Urine.*—The specific gravity is apt to be above normal; it is cloudy, containing much pus, some mucus and sometimes blood. The reaction is acid unless the bladder becomes involved. The quantity of pus varies being sometimes almost absent due to retention, then coming in large quantities due to the obstruction giving away.

An albumen reaction can be obtained due to the quantity of pus present or there may be a coexisting nephritis. Microscopically we find numerous pus cells, epithelial cells, few red cells, and bacteria, usually bacilli.

The general condition of the patients remains good in the



mild cases, but in the severe cases there is more exhaustion, and if the trouble is bilateral it may cause grave anxiety.

The progress of the cases varies. The mild ones toward the end of pregnancy may show only pyuria with slight pain and general malaise, and this will all disappear with delivery. The acute cases may subside in eight to fifteen days and the trouble disappear; or the trouble may recur later in pregnancy; again the trouble may persist for some weeks and be terminated by pregnancy; or it may continue into the puerperium. It is not often that the condition goes on to suppuration of the kidneys, but it may do so and necessitate early delivery or operation upon the kidney. The trouble may come back in subsequent pregnancies, so patients should be informed of this possibility. Cragin advises that these cases should not be allowed to become pregnant again for at least one year after all traces of pus have left the urine.

*Diagnosis.*—There are numerous troubles which this condition may simulate. Cases have been mistaken for appendicitis on account of the pain in the side, fever and rapid pulse. Cases may also resemble typhoid or grippe. The chill and rapid rise of temperature may be mistaken for malaria. It has also to be differentiated from nephritic and hepatic colic, floating kidney, and salpingitis.

The marked pyuria is the chief diagnostic sign—this also emphasizes the necessity of careful urinalysis in all pregnant women. If the pyelitis occur during the puerperium it must be differentiated from intra uterine infection. It may cause grave alarm unless the true condition is recognized.

*Prognosis.*—The majority of these cases will recover under appropriate treatment in from one to six weeks. A few will abort or be delivered prematurely on account of the mother's condition. In severe cases there may be a prolonged labor due to the weakened condition of the mother—she is also more prone to post-partum complications. The prognosis in regard to the child is also good in the mild cases, but in the severe ones they are apt to be premature and weak.

*Treatment.*—The prophylactic treatment consists in the proper hygienic measures during pregnancy, seeing that the patients have a proper amount of rest and avoid exposure. The diges-

tive system should be kept in the best possible condition. Careful urinalyses should be made at short intervals.

The curative treatment consists in putting the patient to bed, having her lie upon the sound side to relieve the pressure upon the affected side. The diet should consist of fluids only. Large quantities of water should be taken to flush out the kidneys. A urinary antiseptic should be used and hexamethyltetramine (urotropin) grains five every four hours has given most excellent results, Salol in like doses may be added. The bowels should be kept open with saline laxatives.

Cystoscopy with ureteral catheterization and irrigation has been suggested, but as the majority of the cases recover without it and it would be very uncomfortable for the patients it has not been generally adopted.

In the severe cases which do not subside under the above treatment, we have to consider more active measures. If the child is viable and the mother is losing ground and there is fear of abscess in the kidney, the child should be delivered. If the inflammation should continue after the delivery of the child and an abscess form in the kidney a surgical operation must be performed. Nephrotomy will cure some cases, if not a nephrectomy will be necessary. Some authors claim that a primary nephrectomy gives better results than the nephrotomy with drain.

*Conclusion.*—There are two forms of pyelitis in pregnancy; one occurring in the earlier months and associated with cystitis, is an ascending infection usually of gonorrhoeal origin; the other form occurs in the latter half of pregnancy, is due to pressure on the ureters, stagnation of the urine, and infection with the colon bacillus.

The diagnosis of this condition is frequently confounded with other abdominal conditions or malaria. The pyuria is the chief diagnostic sign.

The cases which are promptly recognized and properly treated usually recover. Those which are overlooked or neglected may go on to abscess formation and destruction of the kidney.

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## NERVOUS DISEASES CAUSED BY ALCOHOLIC AND METALIC POISONING.\*

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BY J. CHESTON KING, A. B., M. D., ATLANTA, GA.

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Mr. President and Gentlemen:—The subject which I have selected for your consideration, is one which has enlisted the most careful research on the part of the medical profession, and though I may present that which is only *common-place*, yet we can least afford to disregard that which is common place, for old knowledge to new minds involves a constant renewal of youth.

I shall only discuss in a condensed manner the effect of *alcohol*, *lead*, and *arsenic* upon the nervous system. First, what do you understand by the nervous system? It includes the neuroglia, which supports and separates the nerve elements, the blood vessels, which penetrates and permeates the centres and the

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\*Read before the Fulton County Medical Association.

membranes which enclose and protect them. The effects of alcohol on the peripheral nerves are made manifest by a feeling of numbness and pins and needles in the hands and feet, followed by sharp pains, and accompanied by extreme tenderness on the nerve trunks, muscles and skin; there is often in a day or two some inco-ordination in the limbs and then a failure of muscular power. The typical places for the loss of power, are the muscles on the outer side of the leg and on the back of the forearm, supplied by the external popliteal and posterior interosseus nerves. As a result the patient has dropped-wrists and dropped feet, and finds he is unable to extend the toes, to dorso-flex the ankles, to invert or evert them; also in the upper limb, he cannot extend the fingers, the thumb, the wrist. It is almost invariably the case that the corresponding parts of the right and left sides are effected at the same time, and the symmetrical flexion of the fingers and wrists and the extension of the ankles with the foot in a line with the tibia are very characteristic. On the sensory side, besides the tingling and extreme tenderness, there is some anaesthesia of the hands and feet, which spreads up the outer side of the leg and the radial borders of the forearm. Inco-ordination of the arms and legs is sometimes met with. As the disease progresses, the muscles below the knee and elbow are affected, the extensors and then the flexors of the knee and elbow may be paralysed, and subsequently the muscles of the hips and shoulders. In very severe cases, the trunk muscles, the intercostals, the diaphragm, and the heart. The muscles waste very much, and in three weeks time electrical changes occur, so that they seem to contract to the faradic current and give the reaction of degeneration with the constant current, while the nerves lose all response to electricity. If only one set of muscles, viz: The extensors, be paralysed, the unopposed flexors produce a contracture with deformity of the joints.

The knee jerks are lost if the disease involves the extensors of the knee.

The plantar skin reflex is as a rule lost. Sensory disturbances increase along with motor, which they often exceed in extent, and the limbs and their extremities are affected in a particular manner, so that a slight touch is not felt, but firm pressure over the muscles and the nerve trunks gives rise to acute

pain. Besides tenderness, there are acute booring, burning pains in the nerve trunks. The tenderness of the muscles is very characteristic and is well shown by pressing the skin over the anterior tibial muscles, and compare the excessive pain thus produced with the slight discomfort of pressing the skin against the anterior surface of the tibia.

Trophic changes occur sometimes in cases of long standing, in the skin, nails, and joints similar to those occurring in local neuritis. Seldom are the sphinctors affected, and when they are it is due to the disease spreading to the cauda equina or to the spinal cord.

The cause and duration vary much: but in an average case the disease increases from two to four weeks, then remains stationary for a month or two, and then begins to improve. Spontaneous pains become less, but the tenderness still persists; muscular improvements occur in the reverse order of onset, or in other words the muscles which are the first and most affected are the last to recover. In very acute cases, the respiratory muscles may be quickly involved and cause death either directly or by pneumonia. Death may also be caused by other diseases due to alcohol as cirrhosis of the liver, Bright's disease, chronic cerebral meningitis, or from phthisis, a frequent complication. Mental affection, as delirium tremens, may usher in neuritis. These affections may take on the ordinary form of voices jeering at him, or the visional form, as demons or animals in the room or horrid insects crawling over him. Now in these cases of poisonous effects of alcohol in the brain, there is no doubt but that it acts as a direct poison on the cortical cells, in the same way as absinthe will produce epileptic fits by its action on the cortical cells.

We now come to the consideration of lead. Lead may cause not only the peripheral neuritis, but a slower chronic atrophy of the muscles, seen first in the interossei; it is precisely like spinal atrophy, and probably such, but differing in that it does not progress if its causes cease to act, although it is far more enduring than the wrist-drop, it may be permanent, but it does not increase. Lead may cause some form of sclerosis of the cord, usually slight in degree; it may cause optic nerve atrophy; and many forms of functional disorder may result from it. It may cause tremor, chronic convulsions, like those of epilepsy;

and hysteria with its varied manifestations. Neuralgia, sometimes of great severity, may be due to it, and headache is a frequent effect as well as the symptoms of general nervous weakness. In all such cases, in which there is nothing in the symptoms to suggest the cause, this may escape you, unless you are put upon its track either by the occurrence of other associated cases of lead poisoning, by the occupation of the patient, or by the presence of its great sign, *the lead line*. This line is said to be blue, but such is not always the case, I have had recently under my observation, a case where the line was not to be seen at all. You may ask why this prominent point of diagnosis is absent? It is the edge of a deposit of sulphide of lead beneath the inner surface of the gum, where this is separated from the teeth even in a very slight degree. The sulphur comes from albuminous substances which decompose them. Sometimes we see a similar deposit on the mucus membrane of the lower lip, when there is tartar on the teeth with which it comes in contact. Tartar contains organic substances mixed with earthy salts from the saliva, and it yields enough sulphur to act on the lead. It is often the case when we find two or three isolated spots, or on the tips of the projections of gums between the teeth, in this line of patients. A year ago a patient was sent me, for muscular wasting. On examination there was atrophy of the muscles of the forearm, but it was the muscles that suffer in lead poisoning, with characteristic wrist-drop as its result. No others were affected, they had lost ferrugineous irritability and presented very little voltaic excitability. The excitability to voltaism quickly improves in this state after a short treatment.

Lead when taken into the system in repeated small doses affects the nervous system in the form of loss of power and of sensation in the limbs, accompanied by pains or less frequently there are general cerebral disturbances, with convulsions. Where there is no hereditary tendency yet some seem to have a special proclivity to lead as with many other drugs. No age is exempt, women are more liable than men.

The disease that predisposes to lead poisoning is *Gout*.

It is not a difficult matter to detect lead among plumbers, painters, and other trades who use lead, but in people who are not in contact with lead, it is difficult to detect. In the former case it is usually taken into the mouth by men neglecting to wash

their hands before meals, and in the latter through drinking water kept in lead pipes and cisterns, from snuff which has been wrapped in lead paper, from cider or acid stewed fruits kept in porcelain vessels glazed with lead, or from using lotions and washes containing lead. Lead may be absorbed by the alimentary canal or skin, and in animals which have been fed on lead, it has been found after death in the spinal cord.

*Symptoms.*—The chief symptoms which affect the nervous system are paralysis of certain muscles and in other cases cerebral disturbances with mental changes.

Paralysis occurs in two forms, acute and chronic. The acute is the most common, and it represents the typical wrist-drop of lead paralysis, and effects the two sides symmetrically. The first symptom is weakness in extending one finger of one hand, usually the right, and this progresses to other fingers, the thumb, the extensor ossis metacarpi the last affected. There may be no pain or sharp pains along the nerve trunks, with some tenderness of the muscles; while sometimes we see painful spasms or cramps on the muscles. The difficulty is in extending the metacarpophalangeal joints. Later the extensors of the wrists become affected, and then the wrist is dropped, and cannot be moved into line with the forearm. In making the examination of the wrist, we should fix the forearm by laying the limb on a table so that the hand hangs over the edge, and then notice if the hand can be raised at all out of its hanging position. All the muscles on the back of the forearm are affected, except the supinator longus, which is rather remarkable for it is supplied from the same nerve, the musculo-spiral, and can be readily made to contract by the patient fixing his elbow against resistance. The flexors of the fingers are not affected, and this apparent weakness is due to their acting at a disadvantage, their muscles being shortened owing to the wrist being fixed by the paralysed extension of the carpus. Later on the muscles of the upper arm may be involved and especially the biceps, brachialis anticus and deltoidea. General tremors with hyper-excitability to percussion are sometimes observed with twitching of the muscles. The muscles rapidly waste and show changes to electrical testing; to the faradic current, excitability is diminished or completely lost, while to the galvanic current excitability is increased, and the contraction to the

positive pole is obtained with a weaker current than with the negative.

*Pathology.*—The question that now naturally arises is:

“What is the seat of the lesion?” This differs according to whether the symptoms are acute or chronic. In the acute form of double wrist-drop, the changes are essentially those of a peripheral neuritis, having a special selection for the nerves supplying the extensors of the fingers and wrist.

The spinal cord is not as a rule affected, except in the slow chronic form of progressive muscular atrophy. No definite changes have been found in the brain.

Before concluding I wish to make a few remarks on *arsenic*.

Poisoning by small doses of arsenic in occasionally produced either by taking the drug medicinally, or more frequently from cosmetics or sleeping in rooms with arsenical wall papers.

Like lead it causes neuritis, but arsenical neuritis usually affects the legs before the arms, although the latter suffer in severe cases. Moreover its effects on the nerves vary much; the common palsy may be absent and the sensory nerves may suffer much or most and hence the symptoms may be equivocal and even misleading. As a rule the symptoms are acute, and consist of numbness and tingling, and later of sharp burning pains in the limbs, with tenderness along the nerve trunks and hyperaesthesia of the muscles, followed by anaesthesia of the skin and loss of power in the extensors of the wrists and also the toes.

Just as the lines on the gums are the indication of lead, changes on the skin, especially certain forms of pigmentation, constitutes the outward and visible sign of the influence of arsenic. The brown pigmentation begins as small spots, which commence in spots of conjestive redness, and the brown tints succeed the red. It is not so dark as the pigmentation of Addison's disease, and has not the same distribution.

A most important question now arises: How is a differential diagnosis to be made of paralysis due to arsenic, from lead, and alcohol? The absence of a blue line and of any history of poisoning by these two, and the symptoms of ataxia associated with tenderness of the nerve trunks, should help the diagnosis. The paralysis due to arsenic has less tendency to recover than that of lead or alcohol.



## HIGHER MEDICAL EDUCATION.

BY E. R. ANTHONY, M. D., GRIFFIN, GA.

During the last two decades medicine has made wonderful progress. The benefits conferred on the human race by her discoveries in that time have been enormous and have added greatly to the health and wealth of communities and to the happiness and safety to individuals. The great State of Georgia should and will see the importance of the accomplishments of modern medicine and should give us every encouragement and assistance in the struggle for still greater things. We do not ask for money, but we do ask for fair and just legislation that will enable us to reach higher standards of medical education and thereby enable us to solve many important problems now in sight. With all due deference to the grand men and noble characters who worked and toiled in our profession twenty-five or thirty years ago—for I yield to none in my admiration for their devotion to our profession and their skill in its practice—I must say that modern medicine requires a better order of intellect, a higher preliminary education, and a more thorough professional training than it did twenty-five years ago. The weakest part of our system of medical education today is the low standard of preliminary requirements. This standard can not be raised except by legislation. The desire for higher standards, both for preliminary education and medical training has been manifest in all sections of the country. The public holds the medical profession to a strict account for any abuses which occur in connection with medical affairs, and the laity looks to the medical profession to bring about better standards of medical education. The public is already demanding such laws that will assure the adoption and enforcement of higher standards and the legislators who enact our laws are ever ready to listen to public demands. For whom is medical legislation desired? Is it for the benefit of the medical profession and its individual members or is it for the benefit of the public? If it is for the benefit of the profession only, it falls under the head of *class legislation* and no member of the profession would have the gall to work for it, and no legislator would be brave enough to face the frowns of his constituents and aid us in our

requests and demands for it. Every thinking man must now admit that all medical legislation must find its ultimate reason in the benefit to the public and the good to the community at large which it produces. This statement is so plain, so patent that it needs no argument for its proof. Under the Federal Constitution the regulation of the medical profession and its relation to the public comes under the police power of the state and is not a function of the general government. There are at present fifty-two political divisions in the United States. The legislative body of each of these divisions has a right to adopt such legislation and enact such laws as it may see fit, to regulate the practice of medicine in her borders. All of these political divisions (48 states and 4 territories) with the exception of Alaska, have a medical law and licensing board. In several of the states there in four distinct lines of statutory requirements; (1) Preliminary Education, (2) Medical Education, (3) Licensing Test, (4) Registry of License. A large majority of the states have the last three requirements and all have the last two. Quite a number of the states have the first requirement and in a majority of the states legislation requiring a preliminary education is now pending. The present medical law of Georgia was passed in 1894, nearly fifteen years ago. In that time many changes have taken place and medicine has made a rapid progress, thereby necessitating many changes in her law. In analysing the medical practice act of Georgia, we find that the most salient feature will come under the following heads; (1) Character and Composition of Medical Licensing Board, (2) The manner of Appointing Licensing Board, (3) Definition of the Practice of Medicine, (4) Requirements for application for License, (5) County Registration of License, (6) Exemptions, (7) Penalty, (8) Reciprocity. In my opinion, we should ask for no changes in this law under heading *one*. While I think that it would be desirable to have but one licensing board in Georgia with a fair and equitable representative from each school, (Regular, Eclectic and Homeopathic). I do not think it expedient at this time to ask for any change in that direction. Under heading *two*, I think there should be a change. The appointment of the members of the Board should be kept out of politics. The appointments should be made by the Governor from a list of names selected by the Medical Association of Georgia. Under heading *three* there is no urgent necessity for

a change. While the law is not as comprehensive as it should be in regard to the definition of the practice of medicine, we can afford to let it remain as it now stands. Under heading *four* there is a crying need of a radical change. Georgia is the only state in the Union that allows a graduate of a school requiring only three year courses of lectures to apply for examination and license. As a matter of course this should be changed to four years. But the change, above all others, that should be made under this heading is a *preliminary education requirement*. The applicant for license should have documentary evidence of at least a high school education, or he should be examined in such branches as are taught in the high schools, by the Board. This would, sooner or later, force the Medical Colleges to matriculate no scholar having less than a high school education. Headings five, six, seven and eight are about as near perfect as we can get them. I now beg to suggest several amendments to our law. While the changes above suggested and the amendments to be suggested would by no means make our law an ideal one, they would make a great improvement upon the present one law. In the manner of obtaining a temporary license we need a change. Instead of requiring a young doctor to travel all over the state at considerable expense, loss of time and inconvenience, to be examined for temporary license, allow him to be examined either by the President or the Secretary of the Board for license. Another change in the interest of the applicant for license would be the division of the licensing examination into two parts, permitting the applicant to be examined at the end of the Sophomore year upon the subjects he had been taught in the first two years. In Great Britain there are four separate examinations and in France there are five. Another desirable change is this: The Board should be given the power to revoke a license for just cause, such as habitual drunkenness, immoral conduct, producing abortion, fraudulently obtaining a license and the like. Another amendment should be passed authorizing the Board together with the President of the Board of Counsellors of the Medical Association of Georgia to determine *good standing* of Medical Colleges. There are now in the United States about one hundred and sixty Medical Colleges, more than all the countries of Europe combined have. A goodly number of these are nothing more than diploma mills and should not be recognized by the Board.

In conclusion, permit me to say, that if we do not keep the appointment of the Board out of the mire of politics and the Medical Colleges out of the slums of commercialism the standard of medical education will never be elevated to a much higher plane than it now occupies.

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## OUTDOOR LIFE FOR THE PREVENTION AND CURE OF DISEASE.\*

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BY PAUL PAQUIN, M. D., MEMBER AMERICAN MEDICAL ASSOCIATION,  
NORTH CAROLINA STATE LOCAL, ETC., SUPERINTENDENT ASHEVILLE  
—BILTMORE SANITARIUM, ASHEVILLE, N. C.

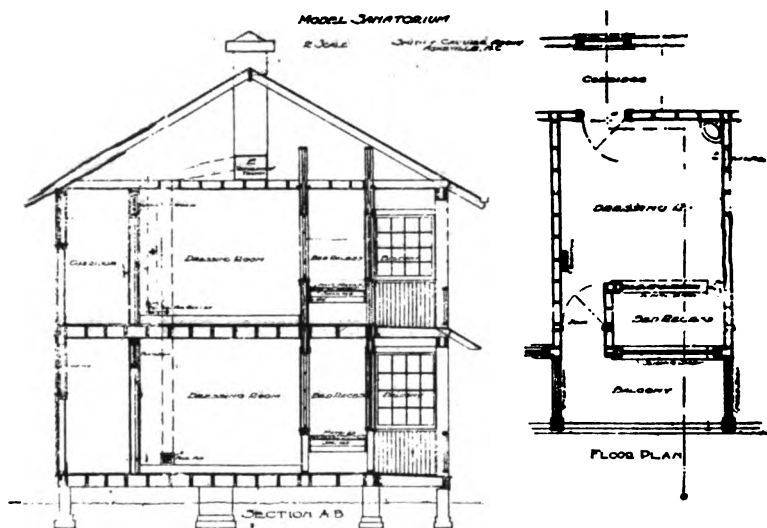
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You mention outdoor life to the average patient, and he or she begins at once to sniff fresh air and to have visions of trees with birds flying about, flowers of various hues and aroma, expanses of prairies, hills, mountains and valleys; streams, rivers and oceans; shooting, hunting, fishing, tenting, shacking and roughing in general. Just about so with the average medical man, for few of the profession have had experience with the problems involved in this proposition, or have given any thought to them. In fact, all that the sentence "outdoor life" conveys to the vast majority of civilization is a vague idea of trying to return to the ways of Nature for help when in physical distress by disease. That the work of civilizing humanity has wrought radical changes in the habits, requirements and resistance of human beings and brought them to habits of life so artificial and foreign to original natural practices as to create second natures, so to speak, scarcely ever enters the mind of anybody. Consequently, the requisites for safe and profitable outdoor life need to be discussed and studied if we would apply it in the prevention and cure of disease; and, as a preamble, I do not hesitate to say that reckless and haphazard outdoor life is no more justifiable than reckless and haphazard drugging. Both have had in the past, and have today graveyard consequences.

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\*Read before the North Carolina State Association, June 17, 1908.

Outdoor life goes back to primitive ages for its inspirations and ideals. The student of nature has discovered that certain maladies, particularly tuberculosis, are diseases of civilization. He has established that the wild man in the woods and jungles is seldom tubercular in his natural home in the open, and becomes involved by contact with civilized humanity. And so, the con-



This model "In and Out Sleeper's" construction shows that the main building is unique, (and the pioneer of its kind in the world). The living and sleeping rooms of guests are erected on the pavilion plan, in a single row, all facing south and southwest, which is the ideal exposure for the longest daily period of sunshine, and for the benefit of the south and southwest breezes. In front of each room is a porch, and back of them (on the north) is a corridor, running the whole length of the building, landing guests at the dining room, the offices, parlors, bath rooms, etc., at one end and on the grounds at the other.

*Each room is so constructed that the occupant may sleep in or out of doors at will, by merely pushing up or pulling down a sash, which is so well balanced that it can be readily moved by the occupant.*

sumptives and their medical advisors prescribe outdoor life, which is well. But pause and consider. Don't push a sick man, woman or child out of doors in ignorance of individual conditions, circumstances and susceptibilities. As a rule the majority are not ready to cope instantly with and be benefitted by the influences of outdoor life in all its forces and moods.

Housing, clothing and inheritance have turned man from wild ruggedness into a hot house plant not always to be exposed without prior preparation to certain atmospheric and climatic conditions, with impunity. You should not expect, for instance, that a man who comes to you as many do, with an overcoat in the month of June, thick coat and vest underneath, a thick flannel shirt under these, one or more undershirts, then a chest protector as dense as cowhide, and finally the skin bound down by sticking plasters—you need not expect, I say, that such a man, stewed in the sweat and filth of his own body, can be suddenly laid out in the open air night and day without some sort of dangerous reaction. The best plan to catch a cold, and also for the pulmonary sufferer to develop a pulmonary congestion, is to sweat and then be exposed to a sudden process of cooling. This is only one way, however, to cause damage by outdoor life. There are many others, and so we need to understand them in order that we may not cause more harm than good in forcing patients to live out constantly.

As fundamental forces for beneficial outdoor life, we may point out above all things, the persistent supply of oxygen with the persistent dissipation of carbonic acid gas without rebreathing it, as compared with the more or less impoverished oxygen supplied in a room, and the constant re-breathing of the carbonic acid gas emanating from the lungs, and the breathing of house air laden with dusts and the dangerous germs of carpets, crannies and darkness, for, in the open air, in favorable localities at least, the germs that float about and which when inhaled might do harm if they had been protected within a building, are comparatively harmless after having been subjected to the influences of sunlight, rains and other atmospheric conditions. These basic factors are the essentials for the prevention and cure of disease by outdoor life. They are immensely valuable contributions to complete nutrition which is the very soul of health. Now, how are we to maintain safely, their good influence about a person, brought more or less out of close communion with Nature by ages of ancestral artificial existence and by individual artificialism and false methods of the present day civilization?

To begin with, we must educate each person, if found necessary, in a manner to restore as nearly as can be normal personal existence as to clothing and exposure to the various elements of

the atmosphere. A person who overdresses and macerates his or her skin with perspiration, must first of all be gradually relieved of the incumbrance and made to live and to remain dry and to become capable of resisting the coolness of the breezes at least, not to say anything about accidental drafts and winds which all humans at times must be prepared to meet. A person must also be taught that cold weather, rains, snows, etc., are not insalubrious—far less than heat perhaps—but that certain conditions affecting these or the persons subjected to them, are damaging; for instance, high winds, storms, direct drafts, sand or dust blowing moisture in low altitude, etc. Above all things, those persons who think that they protect themselves from cold by keeping wrapped up in shawls, coats, sweaters, blankets, etc., as suggested above, and who insist either of themselves or through persuasion, in living day and night in heavy underwear in order to keep off colds, should be taught and made to realize that this sort of so-called protection is a trap to catch colds and congestions and all the attendant catarrhs, and that underwear is primarily to keep the skin and necessary clothing far enough apart to maintain a free ventilation all around the body.

On the other hand, the question of sleeping in or out of drafts, of being close to or far above ground, of getting wet and chilled, or suddenly hot after being cold, of rising at night when sleeping out, are to be considered by doctors and patients, particularly those who preach tents and shacks without ever thinking of surroundings, arrangements and appointments thereof.

In lying down, night or day, one cannot afford to be in a direct draft that strikes only a part of the body. Be it ever so slight, it chills that part more or less, and, except perhaps when the draft hits the face alone, I assure you that usually a cold results. A breeze or light draft that is *not seriously chilling* in its temperature, and which covers and surrounds all the body alike, is not likely to cause a cold or congestion. The ways and wherefores of these facts cannot be discussed in this brief paper. Suffices it to assert them to be a matter of experience.

It is evident then, that one who would live out night and day must be so situated as to be bathed constantly in fresh air with the minimum chances of being subjected to drafts. I need not say of course, that equal protection against chilling winds and rains and snows must also obtain. How can these desired results be

secured? Simply by good common sense selection of a locality to live in, and proper arrangements to live out.

*First.*—Select a fairly high altitude as far from smoke and heavy dusts as possible.

*Second.*—If you choose a shack or tent, have its floors several feet above ground, and be *sure* that it is lavishly ventilated (without direct body drafts), for a shack or a tent of the usual kind is a fraud and a snare, and worse than an ordinary bedroom with open windows. For one thing, a canvas room is usually stuffy and hot, and then it is generally too close to the ground and absorbs moisture with rheumatic and congestive effects.

*Third.*—You might roost up a tree by arranging there some sort of hold-on-to-platform and overhead covering. This suggestion offers opportunities for profitable fresh air life undreamt of by the sick or the profession. It has been tried too, and found less wanting than most any other outing abode, although it appears absurd.

*Fourth.*—By far the most satisfactory arrangement is the specially devised outdoor living and sleeping rooms, called the “in and out sleeper,” whereby one may lie day and night absolutely and completely in the open, surrounded by fresh air always, without any danger from drafts, rains, snows, winds, dusts, etc. This is the method presented last year to the section of hygiene of the American Medical Association. This system obtains today at the Asheville-Biltmore Sanitarium. No weather was ever found bad enough to do the least damage to guests in such quarters. Through the winter in dry and wet weather, everybody slept out. A special draft system at the foot of the bed draws the air past the body without touching it, keeping fresh air through and through in constant circulation, and then a foul air flue system carries the foul air of the rooms to an exit on top of the roof of the building.

In conclusion let me suggest that, after all, outdoor life is merely an aid to suitable nutrition, which is a process that involves not only the use of food and water, but the fullest possible assimilation of all the elements necessary to maintain the equilibrium of physical and mental forces in man, which we call health.

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The thirty-fourth annual meeting of the Mississippi Valley Medical Association will be held in Louisville, Ky., October 13, 14, 15, 1908, under the presidency of Dr. Arthur R. Elliot, of



## CORRESPONDENCE

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### LETTER FROM THE JUVENILE PROTECTIVE ASSOCIATION.

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Dear Sir: For the sake of the children and for the good name of Georgia, let us remedy the evils which exist at the so-called State Reformatory. Please read the statements of a reliable eye-witness, Rev. D. W. Brannen, of Milledgeville: "There is one little building, a hundred feet long and fifty feet wide, two stories high, in which everything is done, cooking, eating and sleeping. The white boys and negroes sleep in the same building, on the same floor, in rooms adjacent. No education and training given, no school equipment whatever, and no real reformatory discipline tending to "fixed habits in morality, religion, and industry," and reformatory is really a Juvenile prison farm. I did not exaggerate. I suppressed.

*A Remedy.*—Why not authorize the white children to be removed from the Prison Farm to the Juvenile State Farm, with 426 acres of land in Jackson County, on the R. R. within six miles of Athens—a splendid location—and let the State make adequate provisions for wards of the State sent to this institution, also investigate annually how the money is spent for her wards, and how they are being trained.

*A Contrast.*—Relative to the work and purpose of the Juvenile State, pardon us for quoting to you the words of a wise and expert New Yorker: "Georgia is surely to be congratulated upon having grasped the highest ideal yet advanced for dealing with the juvenile delinquent, to develop citizenship through citizenship."

Our plan is to start with a \$100,000.00 plant and ask the State to appropriate only one fourth of this amount, on such conditions as the Legislature deems best.

For full information we are sending you under separate cover out 32 page illustrated booklet.

One word more, let negro juvenile criminals be sent to the

State Reformatory—or, we will take the negro delinquents and provided for them in *altogether separate quarters*, a mile apart.

*A Small Western State.*—Montana, with one-fourth the population of Georgia, and much less wealth, has a \$200,000.00 plant for her reform school, and last year appropriated \$42,000.00. How about Georgia?

Believing firmly that you wish to do the best for our most chanceless children, and also that we propose a real remedy for the difficulties referred to above, and further inviting any suggestion of change which you may think wise, we are,

Yours truly,

L. G. Hardman.  
Clifford L. Anderson.  
William W. Landrum.  
W. G. Wi tham.  
E. C. Callaway.  
W. R. Hammond.  
Crawford Jackson.  
J. L. Sudleson.  
Executive Committee

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Dr. S. R. Roberts has recently published a pamphlet entitled, "The Battle of Sex, The White Life vs. The Red Light," in which he presents in a forcible manner urgent reasons for continence in single men. The subject of sex, puberty, marriage, masturbation, venereal diseases, the white life and "the battle," are discussed in a concise, systematic way and in language that can readily be understood by the laity.

The pamphlet, we believe, was prepared for college students, and undoubtedly a wide dissemination of the facts brought out by Dr. Roberts will work great good in lessening the social evil.

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A bill has been signed by the President providing for increase pay for officers and men of the Navy, which, according to the members of the Committee on Military Affairs, puts the officers of the Navy on a parity with those of the Army under the new army appropriation bill.

# EDITORIALS

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We will present, postpaid, on request, to each contributor of an original article, twenty (20) marked copies of THE JOURNAL-RECORD OF MEDICINE containing such article.

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## THE CHICAGO MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

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The fifty-ninth annual session of the American Medical Association which was held in Chicago, June 2-5, 1908, was perhaps, the largest gathering of physicians that has ever occurred in this country. There were about 6,500 doctors present, from all parts of the world; every state in the Union had its representatives; they came from Canada, Mexico, all parts of Europe, also from China and Siam. Among the distinguished foreign guests, were Dr. Schafer, Edinburg; Drs. Collins and Beevor, of London; Drs. Sauerbruch, Plannenstiel; Jansen and Martin, of Germany.

The papers read in each section were by the best men in their special branches. The paper of President Burrell, of Boston, on, "A New Duty of the Medical Profession: The Education of the Public in Scientific Medicine;" and the Oration on Medicine by Dr. Thayer, of Baltimore, on "The Relations of the Physician to the Public," should be read by every practitioner. The paper, however, which impressed me most of all was the address on Surgery, "The Cancer Problem," by Dr. Crile, of Cleveland. This was very forcefully and impressively delivered, and showed that he was a thorough master of his subject.

The different sections were very well attended. The sym-

posium on, "Caesarian Section," in the section of Obstetrics and Gynaecology," brought out some excellent papers. Dr. Pfannenstiel, of Germany, read one; Dr. McPherson, of New York, repeated 186 cases operated upon at the New York Lying In Hospital.

The scientific exhibit was of a very high order; many specimens were shown, not only by hospitals and medical schools, but also by individuals. The commercial exhibit was also most interesting.

The House of Delegates did their work promptly and in a most business like manner. There was perfect harmony, and all seemed to be working for the very best interest of the association. Every one was given a hearing and treated with utmost courtesy and consideration. If there was any political ring at work, it was very carefully concealed.

The entertainments were numerous and attended by large crowds. Chicago furnished accommodations for this large number of physicians without undue crowding. The city has many points of interest and every one seemed to be enjoying himself and commented upon the fact that he was glad he had come.

The next session will be held in Atlantic City. This place was again chosen because it is one of the few places that can furnish accommodations and amusement for so large a crowd. Col. Gorgas was unanimously elected president for next year and this was considered a wise and happy selection by all.

F. G. HODGSON.

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## TO DEVISE PLANS FOR REGULATING PRACTICE OF MEDICINE.

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A very important meeting was held in Macon, June 10th, 1908. Those invited were the Deans of Medical Colleges of the State, the Board of Medical Examiners, the President of the Georgia Medical Association and the Chairman of the Councillors of the State Association. The object of this meeting is to consider and discuss ways and means to regulate the practice of medicine in Georgia. This movement will undoubtedly meet the approval of every legal practitioner in the State, and the Journal-Record will heartily co-operate in any possible plan that may be decided upon.

## MORTALITY STATISTICS.

The reports of the Census office has recently been issued for the year 1906. Unfortunately only 15 of the 46 states are accepted as registration states, but the Bureau of the census is making earnest effort to increase this number in order that the United States may obtain a complete and uniform system of registration. The data upon which these reports are based are not collected by the National Government, but taken from the registration under state laws and municipal ordinances. Naturally it is exceedingly difficult to secure uniform and comparable data from so many different sources and a very important part of the function of the national registration office is to promote the use of identical methods and to urge the enforcement of the city and state laws.

There were 658,105 deaths reported during the year 1906 from the registration area which has an estimated population of 40,996,317 persons, and the death rate was consequently 16.1 per 1,000. The death rate of the colored population is much higher than that of the white population. For the five-year period, 1901 to 1905, the death rate of the whites was 17.5 and that of the colored population was 28.4 per 1,000 or over 60 per cent. greater. About the same relation is shown for the year 1906. If the death rate of the colored population could be further sub-divided it would undoubtedly be found that the mulatto shows a higher death rate than the black negro. This fact alone should be sufficient to make those who claim to favor miscegenation hesitate in advancing their repulsive scheme.

Diabetes is the only disease which has shown a steadily increasing rate for the six years given in the tables. An interesting point in this connection is the claim of Eccles\* that with an increase in the wealth of a nation comes an increase in the number of cases of diabetes, and *pari passu* with this, an increase in the consumption of proteid, with a corresponding decrease in the consumption of carbohydrates.

There were 13,160 deaths from typhoid fever reported from the registration area during the year 1906. Only 95 deaths were reported from small pox, while 5,087 were caused by measles.

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\*Medical Record, New York, May 9, 1908.

Cancer is given as the cause of 29,020. The number of deaths from violence was 49,552. Tuberculosis in all its forms caused 75,512 deaths, and the death rate of 184.2 per thousand is considerably lower than that of any other year shown. Over 86 per cent. of all deaths from tuberculosis are assigned to the pulmonary form.

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### THE NEED OF BETTER WATER AND BETTER SEWERS.

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The committee of twenty-five appointed by the Chamber of Commerce to investigate the demands for a \$1,500,000 bond issue in Atlanta has made a very instructive report and one whose suggestions should be heeded.

It is shown that Atlanta has a much higher death rate than most other cities and that this is not due to climate or natural drainage, but to the following causes:

1. The use of surface closets and well water by over fifty thousand people, on account of insufficient sewerage and water mains.
2. The city water rendered impure at times by lack of proper filtration.
3. Clouds of filthy germ-laden dust blown into the face, eyes, ears and mouths of the people on the crowded streets.

The startling fact is also reported that one-third of the area and 40 per cent. of the population of Atlanta are without water mains or sewers. With 10,805 surface closets in the city and about 50,000 citizens drinking well-water, is it surprising that our annual mortality rate is high and that typhoid fever is such a common disease?

Instead of cutting down the proposed bond issue to \$500,000, it should be increased to an amount sufficient to cover the cost of installing a modern and efficient sewerage system with drains for the street separate from those leading from the closets. The physicians of the city should unite in urging the necessity of a modern sewerage system and removal of all closets if our health is to be held at even an average.

## FRITZ SCHAUDINN.

An interesting review of the work of Schaudinn appeared in the June issue of the Johns Hopkins Hospital Bulletin. Schultz gives a short biography of Schaudinn, the discoverer of the organism now generally conceded to be the cause of syphilis, and as his work in zoology and protozoology has been of such fundamental importance we will reprint a few of the facts concerning his work as presented by Schultz.

Fritz Richard Schaudinn was born on the nineteenth of September, 1871, at Roesiningken, a village of East Prussia. He obtained his degree of Doctor of Philosophy on the third of March, 1894. He died on the 22nd of June, 1906. Concerning his youth little need be said. Into his short life of less than thirty-five years, into a working period of twelve years, there was crowded a wealth of work, which, judged by the standard of quality alone, must stamp the author an indefatigable worker. Judged by the higher standard of quality, his work makes of him a genius, one of those truly wonderful master-minds that appear only once in a long period of time. When he died, scientific medical research lost its most brilliant exponent, a man destined by training and ability to carry us far along certain lines of work. Although much progress will undoubtedly be made along the paths marked out by him, the fullest possible measure of that progress will not be realized until there shall appear another with the trained technique, the keen observation, and the intellect of Fritz Schaudinn.

His observation, in 1894, that an adult protozoan with the organelles characteristic of one class may produce young with organelles supposed to be specific of an entirely different class, may be considered the beginning of Schaudinn's long series of additions to our knowledge of the protozoan life cycle.

He did extensive work on the malarial parasite, ankylostomiasis and amebic dysentery. Much confusion existed as to the part played by the ameba coli and it remained for him to describe the difference in at least two species of amebae and differentiate that associated with dysentery from the species found in the healthy intestine. What would have been the ultimate results of Schaudinn's labors, had he lived to complete them, cannot be imagined until they shall be taken up by another equally gifter.

## MEDICAL AID AND NURSING FOR THE POOR.

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A worthy movement has recently been inaugurated in Atlanta to establish a dispensary district Nursing Association, which is to have as its aim the promotion of medical and educational work among the poor.

This work is headed by the Federation of Woman's Clubs. The plan to carry out this work is as follows:

"First, by establishing dispensaries and clinics, and doing district nursing by Christian nurses.

"Second, by co-operating with the municipal authorities in endeavoring to improve the city's care of the poor, outside the hospitals.

"Third, by co-operating with other charitable organizations for the care of the sick poor.

"Fourth, by doing such educational work as lectures, demonstrations, distributing tracts, and organizing clubs for boys and girls."

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## BOOK REVIEWS

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**SURGICAL DIAGNOSIS.** By Daniel N. Eisendrath, M. D., Adjunct Professor of Surgery in the Medical Department of the University of Illinois (College of Physicians and Surgeons). Octavo of 775 pages, with 482 original illustrations, 15 in colors. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$6.50 net; Half Morocco, \$8.00 net.

W. B. Saunders Company, Philadelphia and London.

Of first importance in every surgical condition is a correct diagnosis, for upon this depends the treatment to be pursued; and the two—diagnosis and treatment—constitute the most practical part of practical surgery. Dr. Eisendrath, in this superb new work, takes up each disease and injury amenable to surgical treat-



men, and sets forth the means of correct diagnosis in a systematic and comprehensive way. The subject has been presented from a clinical standpoint, and the injuries and diseases grouped in the manner in which the surgeon or general practitioner considers them in examining the patient for the purpose of making a diagnosis. The importance of differentiating simulating affections has been constantly borne in mind, and every assistance given along these lines. Special effort, too, has been exerted to furnish the means of making a correct diagnosis in the early stages of the condition. Definite directions as to methods of examination are presented clearly and concisely, providing for all contingencies that might arise in any given case. The chapters on cystoscopy and urethral catheterization are unusually instructive. Dr. Eisen-drath, being a strong advocate of the teaching of surgery by the education of the eyes has had specially made a large number of superb illustration. These four hundred and eighty-two pictures are not only artistic but practical, for each one gives practical assistance in diagnosing the condition under consideration. The work is beautifully gotten up.

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PANAMA AND BACK. The record of an experience by Henry T. Byford, M. D., W. B. Conkey Company, Chicago.

This book is "dedicated to the Panama Canal Commissioners, who invited the President of the United States to run down and see them dig the canal while he waited; and to the President who went to the canal and found them asleep, and didn't wait until it was dug."

Dr. Byford has given an interesting description of his trip to Panama and the Fourth Pan-American Medical Congress of the Southern Surgical and Gynecological Association Banquet at Birmingham, the author gives a most complimentary description. He says it "constituted one of the most beautiful and intoxicating sights of the kind I have ever seen and partaken of, and led to the most exuberant five hour's flow of wit and humor of which I have personal knowledge \* \* \* Hereafter I shall always speak of our Southern wit and humor as the most spontaneous and exuberant in the world. The North is witty because it is partly Irish, the South is wittier because it is entirely American."

ATLAS AND EPITOME OF DISEASES OF CHILDREN. By Dr. R. Hecker and Dr. J. Trumpp, of Munich. Edited, with additions, by Isaac A. Abt, M. D., Assistant Professor of the Diseases of Children in Rush Medical College, College, in affiliation with the University of Chicago. With 48 colored plates, 147 black and white illustrations, and 453 pages of text. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$5.00 net.

W. B. Saunders Company, Philadelphia and London.

Professors Hecker and Trumpp have provided an atlas of exceptional value. The many excellent lithographic plates represent cases seen in the authors' clinics, and have been selected with great care, keeping constantly in mind the practical needs of the general practitioner. The text, also, is admirable. Although concise, it covers the entire field of pediatric knowledge, and the editor, Dr. Isaac Abt, has added all new methods of treatment. Cloth, \$5.00 net.

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A MANUAL OF THE DIAGNOSIS AND TREATMENT OF THE DISEASES OF THE EYE. By Edward Jackson, M. D., Professor of Ophthalmology in the University of Colorado. Second Revised Edition. 12mo of 615 pages, with 182 text-illustrations and 2 colored plates. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$2.50 net.

W. B. Saunders Company, Philadelphia and London.

In this book more attention is given to the conditions that must be met and dealt with early in ophthalmic practice than to the rarer diseases and more difficult operations that may come later. It is designed to furnish efficient aid in the actual work of dealing with disease, and therefore gives the place of first importance to the conditions present in actual clinical work. A special chapter is devoted to the relations of ocular symptoms and lesions to general disease. This second edition has been carefully revised.

**INSOMNIA AND NERVE STRAIN.** By H. S. Upson, M. D., Professor of Diseases of the Nervous System in the Western Reserve University. Attending Neurologist to the Lakeside Hospital, Cleveland, Ohio. With Skyagraphic Illustrations. G. P. Putnam's Son's, New York.

The object of the author of this book is to present a provisional sketch of the origin of the psychoses. The ultimate cause of many of the mental aberrations are not all understood and Upson has made a special study of certain etiological factors, many of which, although apparently trivial in character, are of more importance than we have heretofore believed.

The view taken is that the neuroses and psychoses in general are primarily irritative disorders of the sensory system affecting the remainder of the nerve mechanism indirectly. Illustrative cases are given and mode of action and the location of the irritative lesions are taken up later. Especial stress is placed upon the subject of dental caries and infaction of the teeth.

The subject is well presented and opens up an interesting field of thought.

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## SELECTIONS AND ABSTRACTS

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### MEDICAL QUACKERY.

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The following letter to the British Medical Journal shows that the American Medical Quack does not limit his exploits to this continent, but brings reproach upon our reputation in other countries.

Only this spring at commencement time an unscrupulous scoundrel was selling diplomas here in Atlanta right under our noses. And yet in our "strenuous inactivity" we meekly submit to quacks and quackery.

Sir,—One of the most common consequences of our ineffective Medical Act is the constant use by unqualified men of so-called American degrees. "M. D. U. S. A.," whatever that may mean,

is the "medical degree" usually assumed by the worst characters in this respect. Only a short time ago a person styling himself thus was sentenced to a long term of imprisonment for a grave criminal offence; his career of fraud and crime was for a long time masked and covered by his medical practice, and there is no doubt that, had he not posed as a medical practitioner, he could not with impunity have carried out his many frauds. Lastly I have been investigating the career of a much advertised "Professor" styling himself "M. D., D. Sc. Boston," "the great American doctor," and "eminent American expert." I find that he has spent some portion of his life already in prison for various crimes and misdemeanors, and is at present in custody for other alleged offences against the law. Yet for many years he has succeeded in deluding the public into the belief that he is a reputable American practitioner, and has carried on his frauds under cover of his assumed medical qualifications and many aliases.

Such use of medical titles purporting to hail from America cannot but bring discredit to the country of their assumption.

It behoves the honorable practitioners of America, for whose universities and medical colleges we have a high respect, to do something to put a check upon this reprehensible conduct and to enable the public here to detect the true from the false holders of medical titles.

If the American Medical Association could only induce the Federal Government to issue a State medical register, which could be accepted in our English courts as a register of bona fide medical practitioners of the United States, it would have a good effect and lasting result. At present, in prosecuting these unqualified persons, we are handicapped in not being able to prove the falsity of their pretences in assuming American titles.

It is an interesting factor in unqualified practice that the titles of no other nation are so often utilized by unqualified practitioners as these of the United States. It is also interesting to note that the Medical Acts of the United States are more stringent against unqualified practice than in any other country. Not only has each State its own Medical Act, but each individual practitioner has to take out a license, and the penalties against unqualified practice vary from fines of \$25 to \$1,000 for each offence; imprisonment, which may be additional to fines, varies from nine days to one year, also doubled for subsequent offences.

A medical practitioner of one State cannot practice in another without taking out a license, which license has to be granted by the State Board of Medicine.

Here in England we have to see daily the use of American medical titles by men who not only have in all probability never been in America, but in addition were they in America and were they to practice medicine would be promptly haled by the District Attorney before a judge and fined and imprisoned. Even our own disregistered men and those from whom English medical qualifications have been removed do not hesitate to add to their names American medical titles. To be removed from the *Medical Register* one day and be "off to Philadelphia in the morning" seems to be the natural sequence in this respect.

I have called the attention of the American Medical Association to the subject of my letter to you, and hope that by the ventilation of this important matter in the *British Medical Journal*, something may be done to stop this gross scandal, and I hope I shall have your valuable support.—I am, etc.,

A. George Bateman.

Medical Defence Union, 4, Trafalgar Square, London, W. C.,  
May 7th.

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He Knew.—"Are you in pain, my little man?" asked the kind old gentleman.

"No," answered the boy, "the pain's in me."—*Indianapolis Journal*.

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Mr. and Mrs. Hanson Colbert Moseley, of Prosperity, S. C., have issued invitations to the marriage of their daughter, Lula Caroline, to Dr. George Reeves White, of Savannah. The marriage will take place on Tuesday evening, the 30th of June, at 7:30 o'clock, at the home of the bride's parents in Prosperity. Dr. Ralston Lattimore will be Dr. White's best man.

Miss Moseley is a niece of Dr. James Y. Fair.—*Sav. Press*,  
June 18.

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The Kentucky Antituberculosis Association has appropriated \$2,500 to buy ten cows for its local sanitarium.  
Chicago.

## NEWS AND NOTES

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Dr. Jno. F. Denton made a combined professional and pleasure visit to Dalton, Ga., recently.

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The death rate in the city of New York, for the week ending May 30, was the lowest for any week since 1895.

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Dr. F. G. Hodgson paid a short visit to his old home in Athens during the recent commencement of the State University.

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Dr. Henry Slack, of LaGrange, was in Atlanta for a short stay recently.

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Dr. Edgar G. Ballenger and family are located at Lithia Springs for the summer months.

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Dr. W. B. Armstrong was one of the fortunate ones who enjoyed the A. B. & A. excursion to Brunswick and the sea shore.

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Dr. J. R. Brock, of Dade county, is in the city for several weeks, to attend the general assembly. Dr. Brock represents his county in the upper house.

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The friends of Dr. W. W. Pilcher, of Warren county, are urging him to make the race for congress from his district.

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Dr. Fannin has been appointed to the superintendency of Wesley Memorial Hospital—the place made vacant by resignation of Dr. Glenn.

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A new quarterly medical journal has been established by Dr. Hendrick Stern, of New York, with the title, "The Archives of Diagnosis." The second number has recently appeared and contains twelve original articles of distinct merit, and a general review of the current literature bearing upon diagnosis. The importance of this portion of medicine is so great that we feel safe in predicting success to Dr. Stern in his undertaking.

Dr. Glenn leaves in a few days to take up practice in Columbus, Ga. His many friends regret exceedingly to see him leave this section.

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It will be a source of much gratification to the many friends of Dr. Roy Harris, to know that he is out again after his recent severe spell of typhoid.

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Dr. R. T. Dorsey leaves soon for his vacation and to secure much needed rest after the hard work of the past winter and spring.

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Dr. Floyd W. McRae has resigned from the staff of Grady Hospital. His successor has not yet been selected, but Dr. W. B. Armstrong is being prominently mentioned for the place.

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In the death of Dr. Geo. Grimes, of Columbus, Ga., that community has suffered a very severe loss as he has been one of their foremost practitioners for some thirty years, as well as a leading citizen.

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It is with deep regret that we read an account of the death of Dr. Benj. W. Bizzell, at Phoenix, Arizona, June 26. Dr. Bizzell was formerly a resident of Atlanta and for several years was a member of the board of health.

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Dr. R. R. Kime, who has just returned from the Chicago, Rochester, (Ill.), and the University of Michigan Medical Association, and talks very interestingly of his visit to the Dr. Mayo.

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Dr. E. C. Davis and Dr. E. G. Jones drove through the country to Athens, Ga., in the former's new four cylinder runabout. The entire trip was without mishap and both gentlemen report an enjoyable time.

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Dr. E. Bates Block, whose marriage to Miss Julia Porter, of Atlanta, was one of the recent society events of that city, is still in Europe where he and Mrs. Block are enjoying quite an extended trip to the different places of interest.

# Peacock's Bromides

## The BEST FORM of BROMIDES

Each fluid drachm contains fifteen grains of the neutral and pure bromides of Potassium, Sodium, Ammonium, Calcium and Lithium.

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Prepared from Chionanthus Virginica  
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Chionia is a gentle but certain stimulant to the hepatic functions and overcomes suppressed biliary secretions.

It is particularly indicated in the treatment of Biliousness, Jaundice, Constipation and all conditions caused by hepatic torpor.

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A scientific and delightful remedy for permanent removal of constipation.

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**SULTAN DRUG COMPANY, Pharmaceutical Chemists, SAINT LOUIS, MO.**



We are glad to be able to report that Dr. Theo. Toepel is convalescing from a very severe spell of typhoid fever.

---

Dr. Joseph Mines and family are visiting his father in Birmingham, Ala. Dr. Hines drove through the country in his automobile.

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Since the resignation of the entire house staff of Grady Hospital, Dr. L. D. Pattillo has been serving as house surgeon. The duties of this position are by no means new to Dr. Pattillo, as he already holds certificate for complete service from Grady Hospital.

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A meeting of the Surgeons of the Atlanta, Birmingham and as he already hold certificate for complete service from Grady **included the annual report of the officers**, addresses by the physicians and surgeons employed by the road, and the election of officers. Dr. W. S. Elkin is chief surgeon of the road.

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An effort is being made by each of the Atlanta Medical Colleges, to become the medical branch of the University of Georgia, and equally as strenuous effort being put forth by the Medical College of Augusta, to retain its position in this capacity.

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Prof. Robert Koch is making an extended tour of the United States, where he is being warmly welcomed by the medical profession. His discovery of the tubercular bacillus has resulted in saving an enormous number of lives—**probably more than all other medical discoveries combined**. In the city of New York, alone, in 1881, numbered 6,123, while in 1906 there **were** only about 8,000 deaths in spite of the enormous increase in population.

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At the commencement exercises of Tulane University, New Orleans, May 20, it was announced that the suit of the Newcomb heirs against Newcomb College had been decided in favor of the college, and that after six years of litigation, the supreme court of New York State, had declared that the \$2,000,000 willed by Mrs. Newcomb would now become the property of Tulane for its Department of Women as soon as the formalities could be accomplished.

# BROMIDIA.

TO EVERY DRACHM OF FLUID ARE  
ADDED 15 GRAINS EACH OF PURE  
CHLORAL HYDRATE AND PURIFIED  
BROM. POT.; AND  $\frac{1}{8}$  GRAIN EACH OF  
GEN. IMP. EX. CANNABIS IND. AND  
HYOSCIAM.—IS THE ONLY HYPNOTIC  
THAT HAS STOOD THE TEST FOR  
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SPECIALLY VALUABLE IN  
PROSTATIC TROUBLES OF OLD MEN—IRRITABLE BLADDER—  
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## NEURILLA FOR NERVE DISORDERS NEURILLA

If Patient suffers from THE BLUES (Nerve Exhaustion),  
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General Nervousness, give four times a day one  
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A Modern, Up-to-Date Institution for the care of Medical and  
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### THE RESEARCH DEFENCE SOCIETY.

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A society has been formed in London called the Research Defence Society, whose object is to counteract the propaganda of the antivivisectionists who have been very active in England for the last few years. The society will give information to all inquirers, issue articles and pamphlets, send out speakers and lecturers, and carefully examine the truth of the teachings of the antivivisectionists with their misleading and calumnious statements. It is thought that the passive attitude of the medical profession in the past was a mistake and that it is time to wage an active campaign to show that vivisection has a prominent bearing on public health and welfare, to show the real nature of experimental vivisection, the benefits which it has conferred both to man and the lower animals, and the still greater advances that will be made possible by it in the future. The society will also demonstrate that the medical men who employ vivisection are not less humane than the rest of their countrymen. The society already has more than 800 members among whom are most of the leading physicians and scientists of London and also many well known persons in public life.

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### ARMY MEDICAL DEPARTMENT EXAMINATIONS, 1908.

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The Act of April 23, 1908, reorganizing the Medical Corps of the Army, gives an increase in that Corps of six colonels, twelve lieutenant-colonels, forty-five majors, and sixty captains or first lieutenants, and establishes a Medical Reserve Corps as an adjunct to the Medical Corps. Under this recent act, the lieutenants of the Medical Corps are promoted to captain after three years' service instead of five, and the increase in the higher grades insures promotion at a reasonable rate all through an officer's military career. Furthermore, applicants who are found qualified in the preliminary examination are appointed first lieutenants of the Medical Reserve Corps and ordered to the Army Medical School in Washington, D. C., for eight months' instruction.

# BUFFALO

# LITHIA SPRING WATER

## In ALBUMINURIA OF BRIGHT'S DISEASE PREGNANCY AND SCARLET FEVER

DR. JOS. HOLT, of New Orleans, Ex-President of State Board of Health of Louisiana, says: "I have prescribed BUFFALO LITHIA WATER in affections of the kidneys and urinary passages, particularly in Gouty subjects, in Albuminuria, and in irritable condition of the Bladder and Urethra in females. The results satisfy me of its extraordinary value in a large number of cases most difficult to treat.

DR. GEORGE BEN JOHNSON, Richmond, Va., Ex-President Southern Surgical and Gynecological Association, Ex-President Medical Society of Virginia, and Professor of Gynecology and Abdominal Surgery, Medical College of Virginia: "It is an agent of great value in the treatment of the Albuminuria of Pregnancy."

T. GRISWOLD COMSTOCK, A. M., M.D., St. Louis, Mo., says: "I have made use of BUFFALO LITHIA WATER in gynecological practice, in women suffering from acute Uræmic conditions with results, to say the least, very favorable.

DR. J. T. DAVIDSON, New Orleans, La., Ex-President New Orleans Surgical and Medical Association, says: "I have for several years prescribed BUFFALO LITHIA WATER in all cases of Scarlet Fever, directing it to be drunk ad libitum, with the effect of relieving all traces of Albumin in the urine, and have found it equally efficacious in renal diseases requiring the use of alkaline water."

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OUR POLICIES PROVIDE AS FOLLOWS:

- 1st**—Any suit for alleged malpractice (not criminal), any error, mistake or neglect for which our contract holder is sued, whether the act or omission was his own or that of an assistant—is defended.
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- 3rd**—If we lose, we pay, to the limit agreed upon in the contract.

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LOSSES PAID to Dec. 31, 1907, \$26,629,131.90

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#### THE MEDICAL CORPS.

Preliminary examination for appointment in the Medical Corps will be held on August 3, 1908, and formal applications should be in possession of the War Department prior to July 1st. The applicant must be a citizen of the United States, between twenty-two and thirty years of age, a graduate of a medical school legally authorized to confer the degree of doctor of medicine, of good moral character and habits, and must have had at least one year's hospital training or its equivalent in practice. The examination will be held concurrently throughout the country at points where boards can conveniently be assembled, and due consideration will be given to the localities from which applications are received, in order to lessen the traveling expenses of applicants as much as possible.

The examination in subjects of general preliminary education may be omitted in the case of applicants holding diplomas from reputable literary or scientific colleges, normal schools or high schools, or graduates of medical schools which require an entrance examination satisfactory to the faculty of the Army Medical School.

The large number of vacancies created in the Medical Corps by recent legislation makes it certain that all successful candidates will be recommended for a commission for several years to come.

#### THE MEDICAL RESERVE CORPS.

It is desired to obtain and maintain a list of qualified medical men all over the country who are willing to serve as medical officers in time of emergency, and to such men the President is authorized to issue commissions as First Lieutenants, Medical Reserve Corps. It is recognized that it will be necessary to place only a limited number of these officers on the active list in time of peace, and it is hoped that young medical men throughout the country and medical officers of the militia of the various states may be sufficiently interested to secure positions on the Medical Reserve Corps list.

An applicant must be between twenty-two and forty-five years of age, a citizen of the United States, a graduate of a reputable medical school legally authorized to confer the degree of doctor of medicine, and must have qualified to practice medicine in the State in which he resides. Examinations will be held in the near future and will embrace the practical medical subjects.

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Phenol and Guaiacol are the essential remedial agents in nature's own combination. Complete analysis will be sent on application.

Excellent results have followed its use in the external treatment of Eczema, Erysipelas, Furuncles, Carbuncles, Pruritis, Acne, Rheumatism, Gout, Favus, Tinea, Herpes and Skin Diseases generally.

The gynecologist will find CARBENZOL remarkably efficacious in vaginal and uterine inflammations and infections and, largely diluted it may be used, *per urethra*, in urethritis, prostatitis etc. As a spray, diluted to fit, it is also one of the best remedies we possess in catarrh and hay fever.



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NOTE—One of each once only as "sample" and post-paid on receipt of 50 cents. Two of each or four assorted, including one cake of soap at least for \$1.00 (attach this advertisement to your order). Money back if not satisfied.

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# Svapnia

**Purified Opium  
With a Fixed  
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SVAPNIA possesses the following advantages over ordinary opium:

Freedom from mechanical impurities; elimination of undesirable alkaloids; definite morphine content (10 per cent); lessened tendency to nausea and vomiting; increased palatability; uniform results.

The adult dose of Svapnia (1 to 2 gr.), as well as the indications for its use, are the same as opium. It is in the form of red-brown scales, soluble in water with turbidity, and is best administered in capsules, pills or powder form.

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## Aletris CordialRio

through a specific sedative and anti-spasmodic action on the utero-ovarian nervous system, rapidly controls pain occurring at the menstrual period. Normal circulation in the uterine blood vessels is promptly established and a natural flow follows as a logical consequence.

As used by the profession during more than a quarter century, Aletris CordialRio has proven an effective and reliable addition to the medical armamentarium for relieving — among other kindred conditions — the distress and discomfort of adolescence and the menopause.

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Full information concerning the Medical Corps and the Medical Reserve Corps may be procured upon application to the Surgeon General, U. S. Army, Washington, D. C.

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## MEDICAL ITEMS

**PROSTATIC IRRITATION.**—The influence of residual urine in setting up prostatic inflammation is well known. When the urine is concentrated or unduly acid it becomes doubly irritating. To induce a bland, free, unirritating urine is to remove a common exciting cause of the trouble. For this purpose there is no better remedy than Alkalithia. Shut off the use of rhubarb, tomatoes and strawberries.

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## THE BORDERLAND OF DISEASE

There is a growing tendency on the part of medical men to recognize the pathological importance of certain, at present, little understood conditions of the blood. Some of these indeterminate deviations from the normal present none of the aspects of the anemias, but nevertheless bear a direct relation to increased susceptibility to bacterial infection. The studies of Wright on the opsonins, so called, are of special interest in this direction, inasmuch as they have in a measure converted many of our abstract theories into concrete facts. That certain constituents of the blood may be diminished without apparent decrease of the corpuscular elements or of the hemoglobin, is at last fairly well established, and while the specific properties of these constituents are not as yet definitely known, there is abundant reason for attributing certain phases of malnutrition, as well as a general lowering of organic resistance to bacteria, to their absence or decrease. The clinical expression of this blood weakness, or chemico-physiologic deficiency, is subject to great variation, but the symptom-complex usually consists of a general physical decline, loss of weight, increased tendency to fatigue, and a fickle

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## SACRO-ILIAC DISEASES.\*

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In considering the sacro-iliac synchondroses, it must be remembered that we are dealing with true joints which are capable of distinct motion, but which, unlike the other joints of the skeletal structure, consist of flat, bony surfaces which are opposed in oblique axes. In consequence of this fact, the stability of these articulations is dependent upon the strength and tone of the muscles and ligaments which act doubly by preserving an anatomic relation and protecting them.

The pelvic girdle may be considered as the structural base for the skeleton, having attached to it the strong trunk muscles as

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\*Read before the Georgia Medical Association, Fitzgerald, April 15-16-17, 1908.



well as all the important muscles of the thigh. Hence it is evident that any instability of the pelvic articulations must interfere with the proper action of the muscles thereunto attached, and conversely it is true that any lack of development or alteration in tone of the muscles and ligaments, which protect and hold in position the pelvic joints, must likewise render impossible their normal anatomic relation, and with change of anatomic relation we have impaired function.

#### ANATOMY.

The articular surfaces of the sacro-iliac synchondroses are broad and flat, the obliquity of their axes being in two directions, upward and outward and forward and outward. A consideration of the differences between the narrow approximation of bony surfaces forming the pelvic articulation, and the broad, extensive opposition between the sacrum and the ilium will clearly demonstrate that the stability of the pelvic girdle is dependent upon the sacro-iliac articulations and not the symphysis pubis. As a matter of fact, in cases of extrophy of the bladder, the pubic bones may be absent without seriously interfering with locomotion.

Motion is a normal function of the sacro-iliac joints and consists of a tilting of the sacrum on the ilia or the ilia on the sacrum. The axis of this motion is a transverse one, situated about the middle of the sacrum. It is obvious that in tilting, when the promontory of the sacrum moves forward, the tip moves backward, and vice versa.

Certain physiological conditions bear a direct relation to relaxation of the sacro-iliac joints. It is a well known fact that there is a demonstrable amount of relaxation during pregnancy, which becomes more marked toward delivery. This relaxation may not be sufficiently marked to deserve attention, while on the other hand it may be so great as to cause serious inconvenience as regards pain and discomfort, and materially interfere with locomotion, requiring treatment both during pregnancy and after delivery.

During menstruation, which physiologically may be considered as a miniature pregnancy, there is often a relaxation of the joints in question. This unquestionably explains many of the

backaches occurring at the menstrual period, which may often require mechanical support for their alleviation.

During pregnancy and menstruation, congestion of the pelvic viscera is present, and since these conditions may cause relaxation of the sacro-iliac points, Goldthwait suggests that abnormal congestion of the pelvic organs might cause relaxation, and conversely long standing relaxation of the sacro-iliac synchondroses might induce congestion of the pelvic viscera. It has been shown that these joint conditions often improve after plastic operations on the perineum and cervix, and removal of uterine tumors.

From an obstetric viewpoint the movements of the sacrum are of importance. If the upper part of the sacrum be tilted backwards, the anterior-posterior diameter of the brim of the pelvis is increased, and on account of the double obliquity of the articular surfaces, the lateral diameter is likewise increased. But, when in tilting, the axis of motion, passing through the center of the sacrum, as the diameters of the pelvic brim are increased, the tip of the sacrum moves forward and the diameters of the outlet are decreased correspondingly. A knowledge of these facts is often of value to the accoucheur, since the pressure necessary to produce these sacral movements is not at all unbearable by the patient.

Again, since the trunk muscles, which are attached to the pelvis, play such an important part in delivery, the auxillary expulsive force contributed by the trunk muscles is greatly interfered with if the sacro-iliac joints be relaxed, because in that case the basal attachment of these muscles is insecure. This insecurity may be relieved at the time of delivery by a tight fitting belt or bandage about the trochanters.

In the consideration of this subject it must be remembered that we are dealing with true joints, which are subject to the same diseases as joints in other parts of the body: Tuberculosis, malignancy, injury, toxic inflammations, etc. But it is the desire of the authors to draw particular attention in this imperfect exposition of the subject, to the condition of relaxation and chronic strain, often due to faulty posture associated with toxic inflammation. When we remember that these joints consist of flat, bony surfaces with articular axes in an oblique direction, with no bony projections, and held together only by muscles and

ligaments, it is not surprising that chronic strain and relaxation are so common. Ligamentous and muscular support are quite less ineffectual than where the heads of bones are fitted into globular cavities, or the articular surfaces superimposed upon each other.

It has been observed by us many times that with an existing basal condition of excessive intestinal putrefaction, any injury or undue strain to a joint may precipitate a toxic inflammation. And since the sacro-iliac joints are liable to injury and strain, toxic inflammation of these joints is rather common. This superimposed toxic process is of great importance, since, for the relief of the sufferer, mechanical measures must not only be adopted, but also consideration must be given to the intestinal condition.

The mildest manifestation of disturbance in these joints is a slight strain or discomfort in faulty attitudes, as for example, in stooping. The muscles protect the joints for a while, but as these tire the strain is put upon the ligaments, and as these begin to relax and become tense, discomfort is felt. This is usually relieved by stretching as in so doing the lumbar spine is drawn forward, carrying forward also the sacrum into its normal position, the strain thereby being relieved. Downward strain of these joints is also possible from long standing and is relieved by a change of attitude which brings other muscles into play. Strain may also occur in the recumbent position, the spinal muscles finally tiring and the lumbar spine sagging, carrying backward with it the upper part of the sacrum. After anaesthetics where relaxation has been complete and the patient lying on a hard table which cannot adapt itself to the shape of the back, the lumbar spine sags greatly and it is in this way that the great majority of postoperative backaches are explained. Such backaches are easily controlled by supporting the lumbar spine with a pillow, and holding firmly together the sacro-iliac articulations with a belt, bandage or adhesive strapping. Backaches occur in the same manner in acute illnesses where the general muscular system becomes relaxed and the individual, lying largely on the back, the lumbar spine is permitted to sag.

The same condition of affairs occurs from long sitting if the body is not held erect but is permitted to "slouch," the lumbar

spine becomes flexed, carrying the base of the sacrum backward and straining the sacro-iliac ligaments.

In all these conditions previously described, excepting the toxic inflammations, there has been no actual damage done the joints. The condition of strain and accompanying symptoms have been relieved with change of position. If, however, strain is continued until the bones are displaced, or if the strain be sudden and sufficiently severe to lacerate some of the ligaments, we have a true sprain, accompanied by a sharp pain or "stitch" in the back, with the pain oftentimes referred to one or the other of the sacro-iliac joints. Lumbago is very often simply a manifestation of a sprain of a sacro-iliac joint.

When a sprain with displacement occurs, the displacement is often reduced when the correct attitude is assumed. But if the small irregularities on the articular surfaces of the sacrum and the ilia catch, then manipulation may be necessary for reduction.

Again, if the deforming force be moderate in severity and continued over a long period of time, a condition of "chronic relaxation" is reached, with or without displacement. Great discomfort and disability occur in this condition incident to the instability of the pelvis, due to relaxation of the sacro-iliac ligaments. The attachment of the thigh and trunk muscles to the pelvis, explains any disability that may occur in such a condition.

The sacral plexus of nerves containing branches from the lumbar plexus is situated just in front of the sacro-iliac articulations, and it is obvious that strain or displacement of these joints may produce irritation in the nerve trunks situated anteriorly to them. The symptoms resulting in this way are dependent on the nerve trunks injured and the severity of the injury. In this way, also, referred pains in the lower extremities and areas of anaesthesia and hyperaesthesia are explained. Of greater importance, however, are obstinate sciaticas which, in the vast majority of cases, are due to irritation produced by the sacro-iliac synchondroses. Dr. Goldthwait tells me that nine cases out of every ten of sciatica are produced in this way, and its importance as regards treatment is quite evident. He states that many cases of sciatica cannot be cured unless the sacro-iliac joints are properly treated. Since it is a well established fact that when a nerve is injured, the futility of treatment applied to the seat of pain is quite evident.

When displacement occurs, it is most often backward with reference to the upper part of the sacrum. In acute conditions this displacement is usually unilateral, while in the cases of long standing "chronic relaxation," both articulations are involved resulting in the flat back so commonly seen.

Forward displacement of the sacrum, however, is possible, and in falling from great heights and striking on the feet, it may actually be driven downward with the ilia raised and the legs apparently shortened.

iliac joints, limitation of motion may be shown by motions of the body on the thighs, or by motions of the thighs on the body. If the knees be held stiff and the body bent forward, the amount of forward bending will be limited if the sacro-iliac joints be at fault. This motion is made by the hips and spine up to the point where the hamstring muscles become tense, then it is made by the sacro-iliac joints, hips and spine. When the hamstring muscles become tight and strain is put on the irritable sacro-iliac articulations, the spinal muscles are thrown into reflex contraction and the motion is limited.

The way in which to determine whether this forward limitation of motion is due to the synchondroses or to the spine, is to relieve the tension on the hamstring muscles by permitting the patient to sit, when forward bending will be much freer.

When forward bending is limited, lateral bending is likewise affected, and since one side is usually more affected than the other, a difference will exist between the amount of bending toward the two sides. In standing there will often be a marked lateral deviation of the body away from the affected side. Since the hamstring muscles play no part in lateral bending, no difference is noted whether the patient assume the sitting or standing posture.

Backward bending is usually very guarded, and cases where the body is thrown forward and held in that position, backward bending is, of course, impossible.

Nerve irritation with referred pain is most common in cases of sudden unilateral displacement. The pain may vary from a slight twinge to one severe in character. When the relaxation is slow and the displacement is gradual, the nerve trunks adapt themselves to these changes and referred pain is not so common.

Of the infectious processes occurring in these joints, the non-

tubercular are more common than the tubercular, though both are very rare. Toxic inflammations, however, are quite common, the resultant damage varying from a few adhesions to complete ankylosis. Toxic inflammation may occur as a part of a general polyarticular involvement.

Proper attitude is dependent on normal muscular tone and the security of the base to which the trunk muscles are attached. If this be true, it is evident that with an insecure pelvis, correct posture cannot be assumed without undue muscular effort. With a pelvic girdle whose joints are relaxed, the body droops forward, in which condition the support given the abdominal viscera by the trunk muscles is removed and the abdominal organs sag. In the treatment of these various ptoses due consideration must be accorded the pelvic girdle if the ligaments which hold it secure are relaxed or if, for any reason, it be insecure.

*Symptoms*—The most important symptom to be considered in the diagnosis of this condition is limitation of motion. If the sacro-iliac joints be diseased or strained, any motion which causes strain will be limited involuntarily, as is exactly the case with other joints of the body when diseased. In the case of the sacro-

These tests can also be carried out under conditions in which the sacro-iliac points do not carry the body weight. To accomplish this, the patient lies on his back. Instead of forward bending, the legs are raised, the knee being half stiff. For lateral bending the legs are abducted and for backward bending, the patient lies on the face and the legs are hyperextended. With the patient lying on the back and with the knee bent, all normal motions will be unlimited and painless unless the joint be very sensitive or unless extremes of motion be carried out; outward rotation and abduction are then usually painful.

If only one joint be involved, straight leg raising will be limited on both sides though naturally not so much so on the unaffected side. Pain will also be referred to the affected side no matter which side is raised. The explanation of this is that when the leg on the unaffected side is raised, the hamstring muscles become tense and move the ilium on that side, naturally the sacrum is carried with it and consequently we have motion also on the affected side.

*Pain*—With the exception of limitation of motion, pain is the most important diagnostic symptom in this malady. Pain may

be referred directly to the ancro-iliac joints, but more often to the sacral region, also to the leg and foot. The pain which is referred to the leg and foot may be localized in definite areas. In these cases, pressure over the nerve course elicits no pain, a differential diagnostic point from neuritis.

The pain present is usually worse at night, dependent upon the increased strain which results from recumbency, and is also made worse by any motion or position which increases strain.

In the case of children, the pain most usually takes the form of legache or backache. While it may be present during the day, it is almost always present at night, and is frequently mistaken for so-called growing pains, and sometimes confused with the night cries of tuberculous hip disease.

*Swelling*—There is rarely ever swelling in sacro-iliac lesions unless we have to deal with toxic inflammations, tuberculous and non-tuberculous infections.

*Abnormal Motility* of the synchondroses is present in many cases of sacro-illiac disease due to long continued strain. This increased motion is discoverable by several tests, namely, by forced hypehextension of the thighs one at a time, moving the ilium on the sacrum; with the patient standing, hold one hand over the sacrum and grasp the pubic bones with the thumb and forefinger of the other hand, the legs are then raised one at a time. Again, by grasping the iliac crests with the fingers and holding the thumbs over the sacro-iliac joints, and having each leg raised separately. Still another, by having the patient lie on the back, placing one hand over the synchondroses, the patient raising the legs one at a time.

While there may be actual abnormal motility in the synchondroses proper, motions which increase the strain upon the ligaments of these joints may be strictly limited.

*Attitudes*—On standing the lumbar curve will be ibliterated if the sacrum is diplaced backward, the reverse being true if sacral displacement is forward. The whole body is often thrown forward. The body is usually inclined away from the diseased joint. When rising from the recumbent to the upright position, the spine is held rigid and the hands often used for support. Flexion of the trunk is avoided. Walking is guarded if the condition be acute, and a long step is imposisble, due to spasm of the hamstring muscles. If such instability is present, a rolling or

waddling gait is seen. In lifting weights or stair climbing, the hands are often used for support.

*Treatment*—When in the synchondroses either acute or chronic strain exists, naturally the first indication is to relieve this strain and correct conditions which are instrumental in its production. Long standing should be avoided, and in standing the correct attitude should always be maintained. When sitting, lounging should not be indulged in, and when recumbent, a firm pillow should be placed under the hollow of the back to prevent the lumbar spine from sagging.

In many cases simply relieving the attitude of strain will relieve the strain and nothing else will be needed. But in others, while this relieves, it does not cure, and mechanical apparatus must be devised for the support of the joints. Adhesive plaster straps across the lower back and buttocks, or belts so applied as to support the sacro-iliac joints, combined with a low corset to correct lumbar flexion, will suffice in some cases, but in others plaster-of-paris casts are necessary and more complicated forms of apparatus will have to be devised.

In some cases where the symptoms are due to joint strain, mechanical support will only be palliative. Muscular and ligamentous weakness are the fundamental aetologic factors, for the correction of which, massage, stimulating baths, and special exercises are required.

When sacral displacement is present, the upper part of the bone is most usually pushed backward and rarely apparently downwards. In this condition the bone can almost always be replaced by hyperextending the spine, or by placing the patient upon the back and raising the leg with the knee straight.

A procedure recommended by Goldthwait is "to have the patient lie face downward with the thighs and legs supported upon one table and the head and shoulders upon another, the body hanging entirely unsupported between. The plaster jacket may be applied in this position."

In other cases of subluxation in order to produce complete muscular relaxation, an anaesthetic is necessary and oftentimes more definite pressure is required directly on the sacrum.

In the forward subluxations, flexion of the spine and hyperextension of the thighs is the correct manipulatory procedure. In some cases it will be necessary to manipulate the ilium on the



sacrum. In cases where extreme relaxation is present, recumbency in a plaster jacket will be required.

Recent injury requires the same treatment as strain except that recumbency will often be indicated. Later the patient may be allowed up as the symptoms of judgment dictate. In this type of cases some form of apparatus will have to be worn for several months, followed by massage, exercise, baths, electricity, etc. In cases of strain and subluxation, some form of apparatus should be worn for about three months, followed by the above mentioned methods of strengthening muscular and ligamentous support.

In women a broad belt of webbing attached to the base of the corset and strengthened by steels is very efficient. Woven elastic trunks, fitted about the thighs and buttocks, often prove satisfactory. In stout women the Osgood brace is very efficacious.

A firm pillow under the lumbar spine or some form of apparatus will usually have to be worn at night, as during recumbency the pain is often great.

The fact to which the writers particularly desire to call attention is that toxic inflammation due to excessive intestinal putrefaction may be superimposed upon any of the condition of the sacro-iliac joints herein described, and in order for a cure to be effected, appropriate treatment must be accorded the disturbed digestive function as well as the diseased joints.

The prognosis is good if treatment be extended over a sufficiently long period of time.

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## THE EXAMINATION OF THE FOECES AS AN AID TO DIAGNOSIS.\*

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My excuse for opening this odorous subject is the great practical importance which it has attained in the past few years, and the scant attention it had previously received at the hands of the clinician.

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Read before Fulton County Medical Society, June 4th 1908

As Schmidt very aptly expressed it, "Scarcely any practitioner has proceeded differently from the layman in the investigation of the fœces—that is, he inspects it, smells at it, and at most stirs it with a stick."

One reason for this neglect has been the lack of any systematic plan of examination which was sufficiently rapid, simple and reliable for the clinician to employ, and an interpretation of these findings based upon a large number of examinations.

It was while working in the laboratory of Adolf Schmidt in Dresden in the winter of 1905-1906 that I became familiar with his functional test of the intestines, which is now being accepted both in this country and Europe as the standard. This functional test was developed along the same plan as the test breakfast in gastric diagnosis, and only after much tedious experiment and modification was a test diet developed which conformed to the following requirements: (1) that it should be easily digested, both by a healthy person and one with intestinal disturbance, (2) should contain the requisite number of calories, (3) should contain carbohydrates, fats and proteid in the proper proportions, (4) the food stuffs should be easy for the patient to obtain and prepare, and lastly the method of examination should be simple, quick and in reach of the busy practitioner; and it is this standardized test diet and Schmidt's collated findings in the resulting fœces, both in health and disease, which has furnished a working basis for the investigation of the functions of the stomach and intestine.

The results are still far from ideal, and much remains to be done in bringing this work to the degree of accuracy now attained in testing the gastric functions, but we must remember that it is about ten years behind the corresponding work which has been done upon the stomach.

The daily diet as now recommended by Schmidt, and his co-worker, Strassburger, consists of one and one-half quarts of sweet milk, three and a half ounces of zwieback or toasted stale white bread (avoirdupois weight is used here), two eggs, one and a quarter ounces of butter, four and a half ounces of chopped lean beef, six and a half ounces of mashed Irish potatoes and three ounces of oatmeal flakes. In order to meet the American plan of three meals daily it may be arranged as follows:

*Breakfast.*—One glass of milk, four pieces of zwieback or

two slices of toast bread, one very soft boiled egg, butter size of walnut, a pint of strained oatmeal gruel (made from three ounces of oatmeal flakes, one glass of sweet milk and one glass of water).

*Dinner.*—Two glasses of sweet milk, four pieces zwieback, or two pieces dry toasted bread, butter, four and a half ounces of chopped beef lightly broiled in butter so that the center is still red and rare, six and a half ounces of mashed potato.

*Supper.*—Two glasses of milk, four pieces of zwieback or two pieces toasted bread, butter, one very soft boiled egg.

If milk disagrees, or is repugnant to the patient it may be reduced by one-half and the remainder served at breakfast and supper as milk-cocoa and cooked with the oatmeal gruel. Patients often complain that the diet is too bountiful, and unless quantitative tests of the excrement are being made it is not necessary for the patient to take the entire quantity of the diet, but it is important for the accuracy of the test that the full quantity of the carbohydrates be taken and that the center of the meat ball shall be rare.

This diet should be continued for three or four days, a stool on the third day of the diet being generally suitable for examination. If desired, 5 grains of carmine may be given at the beginning and end of the diet which will indicate by its red color the test excrement. The patient is directed to send the entire stool in a fruit jar or other closed receptacle as soon as possible after evacuation.

The macroscopic examination often reveals points of importance. The shape, size, color and consistency should be noted, and especially shreds or masses of mucous filling the interstices of the formed stool. Only the large, formed, sausage shaped is normal; other forms are generally pathologic. The stool should be thoroughly mixed with a wooden paddle and a portion of the size of a walnut placed in a mortar and very thoroughly ground up with the gradual addition of distilled water until it is of a fluid consistency, and then spread on a black and white plate—one can use to advantage a porcelain or white enamel plate, one-half of which has been painted black. Normally we see only a few brown points scattered over the surface, whereas we may find pathologically: (1) Glassy or membranous pieces of mucus of varying size, the smaller particles lying flat on the plate. (2) Connective tissue threads, white, elastic, and which cannot be teased apart with a needle. (3) Small brown masses or rolls of muscular

tissues, cheesy and friable, showing striation under the microscope. (4) Residue of potato in glassy grains resembling particles of mucus, but they stand above the level of the layer and under the microscope show empty potato cells and particles of starch, staining blue with iodine.

The microscopic examination is of value chiefly to verify and strengthen the macroscopic findings.

Three specimens from the mixed foeces are placed on a slide, one is examined plain, after being crushed to a thin layer with the cover glass; the second specimen is mixed with one drop of 30 per-cent. acetic acid and heated until it begins to boil, then covered with a cover glass; the third is mixed with a drop of iodine solution prepared by mixing iodine one, potassium iodid two and distilled water fifty parts.

The first mount will normally show fine residue and at times isolated muscle fibres, yellow with round edges and showing no striation or very faint; also yellow fatty acid salts of calcium, colorless soaps in shell-like shapes, occasional empty potato cells and hulls from the oatmeal grains.

The acetic acid mount brings out all of the fat contents, and normally we see a moderate amount of small fatty acid crystals scattered over the field.

In the iodine mount we normally see a brown field in which may appear a few remains of starch stained violet from the iodine.

Pathologically we may find: (1) In the plain preparation an increased quantity of muscle in bundles with sharp edges and distinct striations, islands of neutral fat which glow with refracted light when the mirror is shaded by the hand, large numbers of small fatty acid and soap needles, many potato cells containing starch, parasite eggs, mucus, connective tissue. Charcot Leyden crystals if seen, speak for the presence of worms, but are not pathognomonic. (2) In the acetic acid mount the field may be dominated by large fatty acid crystals. (3) In the iodine mount excessive quantities of blue starch, various fungus spores and bacilli stained blue, and yeast cells, which are colored yellow by iodine.

For routine work the chemical examination consists only of reaction, the fermentation test and the test for unchanged bile pigment.

Red and blue litmus paper is floated on the ground-up fluid stool, and normally should be amphoteric, faintly acid, or faintly alkaline.

For the bile pigment test some of the ground up foeces is thoroughly mixed in a small Petri dish with a considerable amount of watery solution of corrosive sublimate (Corros. Sublimate 50, Sod. Chloride 5, Dist. Water 1,000), and allowed to stand for twenty-four hours at room temperature. We normally get a red color, due to the hydro-bili-rubin, but a green color, or even very small green particles seen microscopically, indicate unchanged bilirubin, and is pathological.

For the fermentation test an instrument is used similar in principle to Einhorn's saccharometer, in which the fermentative gases displace the water in an inverted test tube and drive it into an open tube placed parallel and connecting with the first.

A portion of the undiluted mixed foeces of the size of an olive is placed in the lower vessel and mixed with water, the rubber stopper is pressed down until all air is excluded, the inverted closed tube is filled with water and fitted on and the open ascension pipe is left empty. The apparatus is then placed in a thermostat at 98 degrees Far. for 24 hours; at the end of this time the height of water in the open ascension pipe is read off. If more than one-half of the tube is occupied by water it is deemed pathological. Schmidt first placed the pathological limit at one-fourth, and in his last book at one-third, but he has since told me that he only considers one-half or more as pathological.

The litmus reaction should be taken before and after fermentation. In carbo-hydrate fermentation the diluted foeces has become more acid, is lighter in color and the gas in the tube has the odor of butyric acid. In putrefactive processes there is relatively less gas, which is foul in odor, the foeces are darker in color and more alkaline in reaction than before fermentation.

Clinically one of the most important pathological findings in the stool is mucus, which when present always indicates an inflammatory process of the intestines, though inflammation may be present without mucus being demonstrable. The mucus visible in the foeces is almost invariably from the colon, and the smaller the particles and the more thoroughly mixed with the foeces, the higher its origin. I have often seen abundant mucus revealed in the black plate after grinding up, when it had not been visible on

inspection. In these cases the mucus was probably freshly formed high up in the colon, and became incorporated in the foeces while the latter was still in a liquid state.

Mucus which is formed in the small intestine is generally digested before it reaches the rectum, and may only be assumed to be present in the foeces in cases of, (1) liquid foeces, with, (2) rapid peristalsis, where, (3) very small mucus particles show microscopically many bacteria and half digested cells, (4) if the sublimate test is positive, and if, (5) much muscle and potato is visible to the naked eye.

In the sublimate test a green color of all of the foeces, or even microscopic points generally indicates too rapid peristalsis with probable involvement of the small intestine. Complete absence of either red or green color indicates complete absence of bile, from obstruction or suppression.

The presence of connective tissue in any quantity indicates disturbance of stomach digestion, generally a deficiency or absence of HCL, and Pepsin, though in rare cases an excess of HCL, seems to inhibit the development of Pepsin and prevent the gastric digestion of raw connective tissue. Schmidt has found that in the digestive tract, only the stomach is capable of digesting raw connective tissue, and on this account the test diet may be used to advantage in those cases where it is impossible to introduce a stomach tube.

In a large number of cases where I have examined the test diet stool, and also examined the stomach contents, the presence of connective tissue in the ground-up, diluted foeces was always accompanied by gastric hypochylia or achylia, the foeces appearing when stirred as if fine cotton fibres were incorporated in it. If muscle fibers be visible, or an excessive amount be seen microscopically it indicates some disturbance of the small intestine or pancreas.

Pronounced albumin putrefaction in the fermentation test, as shown by small amount of gas formation, foul odor to the gas **and increased alkaline reaction speaks for a severe digestive disturbance** which is connected with organic disease of the intestinal mucus membrane, the inflammatory products of which (mucus, serum, pus) are the promoting cause of the putrefaction. **Experiments have shown that undigested albumin food remains in a digestive tract which has undergone no pathological changes,**

do not develop high degrees of putrefaction. This would go far to explain the high degree of putrefaction seen in intestinal catarrhs, as shown by the fermentation tube, excessive indican in the urine and the general toxemia. A good illustration of the important relation which foecal investigation bears to all branches of medicine, is the pioneer work done by Drs. Hoke and Andrews of this city showing the causal relation of intestinal putrefaction to toxic arthritis, and their experience proves that great benefit may accrue to the patient by combatting the intestinal disturbance, in some cases directing no treatment whatever to the joints,

**Fermentation Test.**—Unfortunately a negative result does not assure us positively that all starch is being digested; only the positive result is of value.

Einhorn has devised an ingenious test of the general digestive capacity, by means of various food stuffs tied to beads and allowed to pass through the digestive tract. Particles of raw catgut, fish bone, raw beef fiber, raw thymus gland, mutton fat and partly cooked potato are fastened in pairs to three glass beads, which in turn are tied on a string; the whole is put in a gelatin capsule and administered to the patient. The string of beads is recovered by means of the stool sieve, and examined as to what materials have been digested. This test will probably be of use in selected cases, but does not furnish the accurate test of digestion afforded by Schmidt's test diet, which in kind, quantity and caloric value, measures up to an average normal food diet.

If the test stool shows excess of fats, visible muscle tissue and normal bile pigment we may suspect pancreatic disturbance, though it often exists with no abnormality of the faeces.

Many attempts have been made to devise some reliable method of determining the kind and severity of pancreatic disturbances, but none of these have succeeded in revealing the slight functional troubles. Schmidt found by experiment that nuclei of tissue cells were only digested by the pancreatic juice, and upon this based his test of pancreatic function. Small cubes of fresh raw beef about 1-8 of an inch square are hardened in alcohol, placed in small bags of gauze and given to the patient with the noon meal of the test diet. The bags are then removed from the faeces with a stool sieve and the meat remains stained and examined microscopically for cell nuclei. If all or the greater part of the nuclei are preserved we have a very severe distur-

bance of pancreatic secretion. More than this we cannot say, as the nuclei may be destroyed by putrefaction in cases of constipation, and moreover it has been found that mild disturbances of the pancreas may be present and still the nuclei be digested.

Sahli's glutoid capsule test, which was devised for the same purpose, consists of a gelatin capsule containing 2gr. of iodoform, the capsule being treated with Formaldehyde to render it insoluble in the gastric juice, but not insoluble in the normal pancreatic juice, the capsule being administered with an Ewald test breakfast, it passes from the stomach to the intestine, is dissolved by the pancreatic juice, and iodine in the saliva may normally be revealed in from fifteen to seventy-five minutes. Certain sources of error have been found in this test, however, so that only the positive test is of value. A prompt and normal iodine reaction in the saliva positively indicates normal pancreatic secretion.

This test combined with the nuclei test informs us as to the extremes of normal and purverted function, but the ground between these two is as yet unexplored.

The examination of the foeces for parasites or their eggs, such as the *Taenia*, *Ascaris*, *Oxyuris*, has long been in general use, and the work of Stiles in the study of *Uncinariasis* has been of the greatest value, especially in this section of the country where the disease is so prevalent. Probably no research work of recent years has been of more social and economic value than this, which often explains and remedies the anaemia and arrested development of a whole settlement of cotton mill operatives or school children.

In those cases where parasites or their ova, or micro-organisms, such as the *amoeba coli* are to be sought for, solid or liquid foeces may be conveniently obtained for microscopical or other examination by the introduction of Cohnheim's foeces extractor, a small glass cylinder closed and bulbous at one end and having a smooth eye for the collection of the foeces, which may be examined while still fresh and warm.

Where the larger parasites, gall stones, entero-liths or foreign bodies are to be sought for, a stool sieve should be employed, the best type of which is Strauss' instrument, consisting of a glass jar like an inverted bell glass covered at the top with a sieve, the foeces being placed in the jar, tap water is carried



by a rubber tube to the bottom of the jar, beats the foeces to pieces, the water overflowing the jar carries with it the finer particles and in this way prevents the obstruction of the sieve, which is a defect of other types.

The tests for occult blood in the foeces are often of value in diagnosis, though we must decide from other symptoms from what point of the gastro-intestinal tract the hemorrhage arises. Observation has shown that in a large percentage of cases of gastric carcinoma occult blood will be regularly found in the foeces day after day, whereas in gastric ulcer it will be present one day and absent the next, therefore requiring repeated examinations in order that a positive or negative result may be of value. These tests for blood are often positive in a healthy person after the ingestion of rare or even well cooked meats, and therefore all flesh should be excluded from the diet for three or four days before the test is made.

The guaic or aloin tests are the most useful, the benzidin test being more sensitive, but reacting also to many other materials besides blood.

VanDeen's modification of Weber's Guaiac test is performed as follows:

A portion of the mixed foeces the size of an olive is rubbed to a mushy consistency with distilled water, to which is added one-third of its volume of glacial acetic acid and shaken, an equal volume of sulphuric ether is added and carefully shaken through. The ether is then decanted. One part of resin of Guaiac or chips of guaiac wood are heated with twenty-five parts of absolute alcohol, and ten drops of this guaiac tincture added to 2cc of the ether extract, and drop by drop, 20 to 30 drops of old ozonized oil of turpentine. If haematin is present a blue color of varying intensity appears, which fades in a few minutes.

A point which is often overlooked is that the guaiac extract shall be freshly made and the turpentine must be old and ozonized, or the test is unreliable.

As a substitute for the guaiac one may use a knife point (5gr) of aloin dissolved in 10cc of 70 per cent alcohol, and proceed as above, the positive reaction showing a deep cherry red.

I have employed the Schmidt function test of the intestines in a large number of cases in the past two years, and I am con-

vinced that its value as a diagnostic aid ranks equally with the analysis of the gastric contents in diseases of digestion and metabolism, indeed one test is the complement of the other in the investigation of these conditions.

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## THE USE AND ABUSE OF DRUGS IN TUBERCULOSIS.\*

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BY WILLIAM M. JONES, M. D., HIGH POINT, N. C.

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To what and where are we drifting in our therapeutics regarding tuberculosis and particularly that form known as Phthisis?

Since the beginning of Medical History, tuberculosis has been attacked from every known point, and by all kinds of men, with as many different varieties of treatment as was possible for the brain to conceive of. Why is it that we of today have not profited more by success or failure of our professors? Is it because of the fact that we have lost sight of the minor considerations in our insane endeavor to obtain a specific? We know that this disease has been successfully treated by men of the past, and that our results of today are but little more encouraging, than those of a hundred years ago.

By an examination of the history of the past few years, we find that the favorite of today, has invariably been the outcast of tomorrow. This has caused no small amount of distrust for the use of drugs, and we stand ready to discard them from our armamentum, and to rely entirely, on climatic, dietetic, and hygienic measures. That drugs are of value no one can deny,

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injury, the fatality of treatment applied to the seat of pain is although there may be differences of opinion, as to the position they occupy, when compared with other methods of treatment.

The narrow scope of this paper will not permit me to enter into any discussion other than the internal administration of drugs, and in this I shall not attempt to discuss their physiological action, or to mention more than a few of the more frequently employed, and confining my remarks in the main to such data as I have gained by observation.

Post-Mortem statistics present conclusive evidence of the curability of this disease, when we remember that there is at least as great a per cent, as 90 per cent. to 98 per cent. of all persons who reach the age of 35 years, who show healed tubercular lesions, we must infer that drugs have been instrumental to an extent in this restoration.

Caswell in 1836 said: "Pathological anatomy has never afforded stronger evidence of the curability of a disease than in the case of Phthisis."

Drugs used in tuberculosis are supposed to act in one of two ways; directly on the Tuberculae Bacillae, causing their destruction, or prohibiting their growth and proliferation; indirectly by the increase of weight and consequent increase in the strength and resistance of the patient. In regard to the destruction of the T. B., there is no drug or combination, of such strength, that will not at the same time destroy the surrounding tissues, though some may have the power to lessen their growth and proliferation.

Tuberculosis is seldom such, pure and simple. By this I mean to convey the idea that tuberculosis per se, is rarely to be found as the only pathological condition that is affecting the patient; even in early incipient cases there is often a mixed infection, and a slight leucocytosis with anemia.

When we use the term Abused, we do with the intention of conveying the idea, that it is contraindicated, whether from a physiological standpoint, or one of idiosyncrasy, or on account of some complication that is affecting the patient, and thereby contradicts its administration.

The first that we shall consider is Cod Liver Oil, this is a fixt oil obtained from the fresh livers of the *Gadus Morrhua*, or other forms of Cod-Fish. This drug, or food as it is sometimes called, has to the mind of the laity become almost synonymous with tuber-

culosis and to such an extent that whenever a patient is taking cod-liver oil the inference is that he has consumption.

In the administration of this drug, it will be found advisable to begin with a small dose and gradually increase, using a few drops of Ether to assist in the digestion, and a small amount of oil. Eucalyptos may be added to disguise the taste. By this means patients will be enabled to consume larger amounts and for a longer time without the usual amount of digestive disturbances, that so frequently accompany its administration. The most that can be said of it, is that it is an easily assimilable fat, and as such causes an increase in the weight and strength of the patient, and thereby an increase in his resistance. We are aware of the fact that the market is simply deluged with patent and proprietary preparations, purporting to contain from 40 to 50 per cent. of oil, when in reality they seldom contain more than 8 to 10 per cent. and this not always cod-liver oil, but some substitute. Many of these preparations contain alcohol, and are therefore stimulants and not nutrients. Whenever this drug can be used without derangement of digestion, or other inconvenience to the patient, it is of advantage; on the other hand, when the opposite effects are produced, it is of very decided disadvantage, and its administration should be immediately discontinued.

The same may be said of other oils as of cod-liver oil, and cotton seed oil is preferred by many on account of the fact that it may be administered for a long time, and in larger doses, without so much derangement of digestion, and little inconvenience as regards taste, and on account of the fact that it may be administered during the hot months of summer.

Creosote, like cod-liver oil has become so fixed in the minds of the public, that they think that its only therapeutic use is in tuberculosis. The creosote that is usually found on the market is an impure phenol; and it is only the pure beechwood that should be used for internal administration. The employment of creosote in tuberculosis was based on the statement of Guttman: "That T. B. were destroyed by blood containing one of creosote to 2,000 and that one-half of that proportion would arrest their development." This was only theoretical, for we know that what good effects are derived from creosote are due to the formation of soluble compounds between the remedy and the toxic album-

enous by-products of the T. B. which are eliminated by the blood.

The carbonate of guaiacol is preferred by some clinicians, as it is the principle ingredient and of more definite composition. Creosote was first advanced as a remedy in tuberculosis by Reichenbach in 1833, and revived by Gimbert and Bouchard in 1877, since which time it has been used by men of reputation and ability, who have reported so favorably and in so many instances, that there is at least strong *prima facie* evidence in favor of creosote and its derivatives. But we must not lose sight of the fact that it is often the cause of digestive derangements, and when ever this is the case, its use should be immediately discontinued. One specialist has said as regards the digestive derangements: "In the majority of the cases sent to me, the digestive troubles, may be attributed to excessive doses of creosote, which had been administered by the family physician." It would be an act of presumptuousness, for me to attempt to discuss the great disadvantage to which a physician is placed in his endeavor to treat a case in which the stomach is weak and non-retentive to most of his remedies. Nevertheless this is a state of affairs or condition that we are often compelled to face, and one that will tax our patience, skill, and ingenuity to the utmost.

Ichthyol (Ammonia-Ichtryol-Sulphate) this though a comparatively new preparation, being first brought to the attention of the profession, as a remedy for tuberculosis in 1894 by Cohn and Scarpa, since which time it has been extensively employed and the results have exceeded the hopes and expectations of the most sanguinous.

It retards the disintegration of albuminoid substances and favors their formation and assimilation, increases peristalsis, and has a laxative action on the whole intestinal mucus. It is excreted by the feces and urine, but not directly, as it is first absorbed and then excreted, this being verified by the fact that from seven to ten hours are consumed in its elimination. It causes an increase in body weight, lessens cough, and alters expectoration from purulent to mucoid, stimulates the digestion, thereby causing an increase in the appetite, and lessens night-sweats. Though not very pleasant to the taste it is seldom the cause of nausea. It may be administered in pill, capsule, or emul-

sion, and should in all cases be well diluted with milk or water, preferably immediately after meals. Of all drugs used in tuberculosis, I consider this far the superior, not alone from my own observation, but from the reports of well known physicians, and those of reputable institutions. It has been said, "that the only objection to its use was the cost."

A few words regarding the use and abuse of drugs when administered for special symptoms or complications.

It is in the management of the cough that drugs are more abused than in any other complication affecting a case of tuberculosis. The patient complains that he is annoyed to such an extent that he cannot sleep, on account of the harassing cough, and seeks relief from this distressing condition. In the majority of instances, he is given some mixture containing opium, or some preparation of a sedative and hypnotic character, and possibly containing a little potassium iodide, in a menstrum of syrup, that will mask the symptoms and aggravate the condition. The cough may have been due to some cardiac derangement, the terebinal fillaments of the vagus may have been irritated, and elongated uvula, inflammation of the eustation tube from middle-ear disease, laryngitis, post-nasal polip, etc. In the event that you are unable to find the direct exciting cause of the cough, and it is of such character, that relief is imperative, a little Heroin will in the majority of cases be all that is necessary.

Antipyretics have no place in the treatment of tuberculosis, as they only mask a symptom and do not affect a cause, with consequent depression of the heart and that of the general system. Rest absolute of mind and body will bring about all the reduction that is necessary, and in the event that it does not reduce it, antipyretics are not called for.

Hemorrhage.—The drug most often used, and one that some of the recent text-books recommend is Ergot. Ergot is of value in hemorrhage of any organ with the exception of the lungs, here it is as surely contraindicated, and more so than that of any drug that I can at present call to mind. The reason is that ergot is a stimulant to the vasor-motor centre, causing a contraction of the small arteries and arterioles, and by this action lessening the escape of blood, but at the same time causing an increase in arterial tension and raising the blood pressure. The lungs being separate and distinct in their minute histological ana-

tomy, as to circulation, accounts for the contraindication in the administration of ergot. The terminal branches of the pulmonary artery do not anastomose as do the terminal branches of other arteries, and the walls of the pulmonary vessels are much thinner and consequently weaker than others, and as a natural sequence when ever the blood pressure of the entire anatomy is raised, these weaker vessels are the first to give way and rupture under the increase, and the condition is thereby aggravated. Rest combined with small doses of atropine will generally stop the flow in a short time.

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## CHRONIC STOMACH ULCER; ITS SURGICAL TREATMENT.\*

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BY EDWARD G. JONES, A. B., M. D., PROFESSOR OF SURGERY IN THE ATLANTA SCHOOL OF MEDICINE.

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This paper contemplates a discussion solely of:

I. The diagnosis and treatment of chronic gastric and duodenal ulcers;

II. A brief notice of some objections urged against the operative treatment of these ulcers.

No consideration is intended to be accorded such related pathologic conditions as perforation, adhesions, pyloric stricture, etc., although it is acknowledged that these sequelae constitute a natural, and almost necessary, part of any intelligent study of the subject as a whole. Nor will any effort be made to distinguish clinically between gastric and duodenal ulcers

### I.

The symptoms upon which an opinion may be based with reasonable certainty before operation are, in the order of their diagnostic value:

- (a) History of intractable dyspepsia.
- (b) Hematemesis or melena.
- (c) Pain.
- (d) Epigastric tenderness.
- (e) Regurgitation of sour material.

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- (f) Vomiting.
- (g) Hyperchlorhydria.
- (h) General impairment of health.

(a) Practically every patient who is the subject of a gastric ulcer comes to the doctor with a history of *dyspepsia*. *Every single case of chronic intractable indigestion should be considered with stomach ulcer in mind.* Every thinking physician can recall cases of years ago which he now knows were stomach ulcer—and some of these patients are dead as a result of the failure to recognize and properly treat the condition.

(b) It is practically inconceivable that a stomach ulcer should have developed without *hemorrhage*, slight or otherwise, at some time in its history. Therefore, hematemesis or melena, or both, are very common symptoms. However, the amount of blood may be so small that its detection is impossible except with the microscope or by chemical tests; and it may, of course, be quite impossible to obtain a specimen in which there is any blood at all. Actual visible hemorrhage occurs in fifty to eighty per cent. of cases.

(c) *Pain* is usually described as burning and gnawing in character. It radiates from the epigastrium as the chief point of intensity. Its appearance some time after the ingestion of a meal rather than immediately is evidence suggesting pyloric or duodenal location of the ulcer.

(d) *Epigastric tenderness* can almost always be elicited upon pressure.

(e) *Gastric regurgitation* is a very common symptom indeed. The patient often accompanies the description of his ills with the statement that he frequently wakes at night to find himself in the act of throwing his head over the side of the bed to spit out a mouthful of sour material. There is hardly any point in the history of the patient which is considered by the Mayos as more significant than this.

(f) *Vomiting* is frequently induced by food, which acts as an irritant to the sensitive ulcer. Indeed, this feature may reach the gravity of marked inanition.

(g) *An excess of HCl* in the vomitus or in a test meal is confirmatory evidence of ulcer.

Of course, no physician would expect to find all of these



symptoms exhibited with typical clarity in any one case. Indeed, a minority of cases exhibit all of them in any degree.

Regarding the tripodal relation sustained by the three symptoms of pain, hemorrhage and vomiting to the diagnosis, Mayo Robson says "I have seen and operated on quite a number of cases in which pain had not formed a prominent symptom, in which hematemesis had been entirely absent, and vomiting had not come on until stenosis of the pylorus had produced dilatation."

However, after the clinical diagnosis has been made and operation decided upon, there remains the necessity of confirming the diagnosis by actually recognizing the ulcer with the eye; and a most vital question which confronts every beginner is: How shall I recognize the ulcer, if it be present, without opening the stomach? This ordinarily is not difficult. The serous coat is adherent to the base of the ulcer and there is, consequently, a characteristic cicatrized, puckered area with indurated margins and clearly evident externally.

Should the ulcer not be found anywhere on the anterior wall of the stomach or in the region of the duodenum, the finger should be thrust through the gastro-hepatic omentum or through the mesentery of the transverse colon and the posterior wall subjected to thorough palpation. Only occasionally does it happen that one is left in doubt about whether or not the ulcer is present. It is conceivable, of course, that the serous coat may not be involved to a point which leaves no doubt. There may be slight suspicious adhesions and a suspicion of induration in the muscular wall. Under such circumstances it is probably better to open the stomach and actually examine its internal surface before proceeding. Only recently the writer felt obliged to do this when the presence of an ulcer was doubtful. All authorities are now agreed that it is unwise to perform gastro-enterostomy unless the ulcer can be actually demonstrated at the time of operation.

**TREATMENT.**—There is no longer any doubt as to whether the proper treatment of the average chronic gastric ulcer is medical or surgical. The mortality following the proper surgical treatment has been reduced to about one per cent.; and the number of patients remaining entirely cured after a lapse of two years or more in the clinics of the Mayos, Moynihan

and Mayo Robson totals 90 out of every 100; whereas, under medical treatment alone stomach ulcer recurs or relapses so often that some 50 per cent. of patients ultimately succumb to the disease or to one or the other of its complications.

*Until a very few years ago it was taught that gastric ulcer was a medical disease except when uncontrollable hemorrhage or perforation demanded surgical intervention.*

The diagnosis, therefore, being confirmed by observation, some operation on the stomach is called for. The nature of this operation depends largely upon the location of the ulcer and takes cognizance of the tremendous liability to subsequent malignant degeneration. Two propositions may be laid down:

(1) Excision of the ulcer is desirable in order to remove the threat of cancer;

(2) Excision will not usually be practiced because (a) probably the majority of these ulcers are duodenal, and duodenal ulcers seldom become malignant; (b) the excision of an ulcer in the pyloric region means to produce a potential stricture, if not to practically obliterate the pylorus; the alternative being to resect the pyloric end of the stomach—which can always be done safely.

The following procedures are practiced by the men of largest experience:

(1) An ulcer proximal to the pyloric region is to be excised and no gastro-jejunostomy done, if it is certain that the excision will not cause subsequent obstruction.

(2) An extensive pyloric ulcer calls for resection of the pylorus if the surgeon be skilled and the patient's condition will allow—this resection being supplemented by gastro-jejunostomy.

(3) Duodenal ulcers or gastric ulcers not removed for any reason are to be treated by simple gastro-jejunostomy.

This last procedure, in fact, in practice, is the method of treatment of a vast majority of these ulcers. This operation has, especially in the last three years, been followed by most brilliant results. It cures stomach ulcers by affording adequate drainage, which is a desideratum at least temporarily in that it prevents stasis and hyperchlorhydria and discourages gastric grinding—allowing physical and chemical rest to the ulcer.

Undoubtedly the posterior no-loop gastro-jejunostomy is the operation of choice, the first part of the jejunum being anastomos-

ed to the posterior wall of the stomach through a slit in the transverse meso-colon. An object always to be kept in mind is the prevention of subsequent regurgitation of bile, and with the technic as perfected chiefly by the Mayos and By Moynihan this sequel practically never supervenes. The Mayos make the stomach incision oblique from above downward and from right to left upon the assumption that the "natural course" of the jejunum is downward and to the left from its point of origin. Moynihan makes a vertical incision in the stomach wall upon the assumption that the "natural course" of the jejunum at its origin is directly downward. In no case should there be an attempt to reverse the jejunum as it is applied to the stomach.

## II.

Internists have been quick to condemn the operation of gastro-enterostomy, maintaining that it is too violent an insult to the physiology of digestion. The clinical answer to such a statement is a sufficient answer. I take it that if the patient gains weight and strength, loses his epigastric tenderness, forgets his previous constant indigestion—even forgets that he has a stomach—and leads a comfortable existence with no evidence of impaired metabolism, he may well exercise little concern as to whether his digestion is interfered with or not.

It is claimed, first, that the secretion of the stomach is interfered with. There can be no doubt that gastric acidity is lowered by the operation, but when we remember that hyperacidity is at least one of the causes for the persistence of the ulcer, this decreased acidity subsequent to operation cannot be regretted.

It is objected, in the second place, that the motility of the stomach is impaired. It is probable that when stasis had previously existed the stomach empties itself more quickly after operation than before, but this relief of stasis is certainly something to be desired, whether the food pass through the pylorus or the stoma.

It is urged again that following gastro-enterostomy there is a pathologic presence of bile and pancreatic juice in the stomach. Since these are alkaline secretions it is not entirely unreasonable, as suggested by Patterson, that their presence there is beneficial, at least temporarily, in overcoming the hyperacidity. In those cases, however, where careful technic has been employed it

seems hardly probable that bile is habitually present in the fasting stomach.

It is still further objected that the entrance of gastric contents directly into the jejunum through the anastomotic opening lessens the pancreatic flow, and consequently interferes with fat and proteid digestion, since the presence of acid chyme in the duodenum has long been revered as the natural stimulus to pancreatic activity. However, since the jejunum and the third portion of the duodenum are developed together from the midgut, it is not surprising that the pancreatic flow is stimulated by gastric contents in the jejunum as well as in the duodenum.

I am fortunately able to present before you a patient on whom some experiments have been made under my direction since I operated on him six months ago. He is shown not because there is anything unusual about his case, but rather because he exhibited prior to the operation every one of the symptoms which have been discussed, because of his exceedingly satisfactory recovery and because of the observations made subsequently. He suffered with persistent dyspepsia for three years. His vomiting for two or three weeks before operation was just as regular as the ingestion of a meal and his pain was particularly gnawing in character. Since the operation was done in January he has been entirely relieved of every one of his unpleasant symptoms and has not vomited a single time even from the ether at time of operation, excepting on one occasion about two months ago when he suffered for a day or two with an attack of acute gastritis from the eating of over-ripe fish. He is not conscious of a digestive apparatus and has gained, according to his own statement, 50 pounds.

Some experiments made upon this patient in reference to the objections previously discussed resulted as follows:

Several observations beginning two months after operation showed an average reduction of total acidity of 16% below the mean normal.

The stomach has been found empty twice five or six hours after meals. Examination three hours after a full meal of meat showed 60 c. c. of gastric contents.

Bile has appeared to be present once as a faint trace and absent three times in tests made from one to three hours after meals.

Examination of his feces showed no apparent increase in fat three times and an increase one time. There is no indication of interference with normal digestion of proteid material.

Therefore, at least so far as this particular patient is concerned, if we may be allowed to judge from his general appearance, from his own subjective symptoms, and from the observations above mentioned, there can be no valid objection whatever to the treatment to which he was finally subjected, while medical treatment practiced for three years had failed. Of course, the clinical and laboratory results in a single case like this cannot be taken as proving anything, yet it is to be remembered that they are quite in accord with the clinical results obtained in great numbers of cases.

### DISCUSSION.

*Dr. W. B. Jones.*—It seems a rather strange thing that by far the greatest amount of surgical work upon ulcer of the stomach has been done by the Mayos in the West. I cannot think that gastric ulcer is less common in this part of the country than there; nor can I think that the average surgeon, under whose observation such patients come, is deficient or thoughtless in his diagnosis. The fact nevertheless remains that comparatively few surgeons in the United States, except the Mayos, have any very large experience in treating gastric ulcer by operation, which is undoubtedly the proper treatment. In this particular section, I do not believe that the average person with a stomach ulcer ever goes to the surgeon or is ever sent there.

While I should not like to put myself in the light of assuming a critical attitude toward the stomach specialists, I fully believe that the vast majority of patients suffering from stomach ulcer go to the stomach specialist and remain under his treatment exclusively. I believe this is the reason there are so few opportunities offered for surgical treatment.

*Dr. J. C. Olmsted.*—In expressing my interest in the subject under discussion, and my appreciations of the treatment accorded it by Dr. Jones, I am led to reflect upon the responsibility of the general practitioner in sending his patients to the proper place for treatment of their stomach troubles if he does not wish to treat them himself. I mean to say that the average practitioner has too little to do with where his patient goes for stomach trouble;

I mean that he frequently fails to exercise the proper care in determining himself what is the matter with his patient's stomach, and therefore fails to exercise his right and his duty toward his patient in that he sends him at once to the stomach specialist when he perhaps needs other treatment than that usually practiced in the office of these most estimable and necessary gentlemen. Far be it from me to reflect in any sense upon their work. There is a very large class of individuals whom they do much good; nevertheless there is also a very large class whose chronic attendance upon the stomach doctor's office makes it remind one of a barber shop.

*Dr. Jones closing:* I had in mind myself the fact that under present conditions everybody with stomach trouble of any kind goes at once to the stomach specialist, who undoubtedly in the majority of instances benefits the patient—and to a degree not done by medicine until the stomach specialist appeared—but it is admittedly a fact that an exceedingly large percentage of patients who are improved under proper diet, rest, etc., have recurrences or relapses; so that they cannot fail to discourage the doctor. If, now, surgical intervention has reached such a point of development that it is without any marked degree of danger, and at the same time is almost certainly curative then, beyond any doubt, these are surgical cases.

The danger following an ordinary gastro-enterostomy is by no means as great as the danger of perforation, hemorrhage, stricture, etc., to say nothing of a life made more or less miserable by the chronicity of the curse. As previously stated, some 90 per cent. of patients subjected to gastro-enterostomy report themselves as entirely free of all previous unpleasant symptoms two years and more after operation; and it is to be remembered that this report is from patients upon whom the operation was done before it reached its present stage of perfection, the inference being that two years hence a like report will be still more encouraging:

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The Academy of Sciences at Rome, Italy, announces the endowment of a prize of \$2,000 to be awarded perpetually every two years for the best work on pure and applied chemistry with special regard to physical and general chemistry. The prize is open to the world.

## OBSTETRICAL WORK FROM THE STANDPOINT OF THE GENERAL PRACTITIONER.

BY A. B. CROOM, M. D., MAXTON, N. C.

This subject is one which should interest every medical man; for no section is without its share of such work, and to the general practitioner or family physician usually falls these duties.

Obstetrics, we all concede, is a line of our profession entirely distinct and yet very closely connected with the general practice of medicine. Still it is a line of work falling more on the surgical than the medical side.

It is my desire in these brief remarks to emphasize the surgical side and to point out or call attention to what I regard as a few of the most important points to be remembered in attending the usual run of lying-in cases.

1st. Remember that in complicated conditions, when interference is necessary, an experienced and skilled obstetrician is required, and even when we feel ourselves thoroughly competent to do the said skilled piece of work that an assistant should be called.

2nd. Of still more importance is it to remember that Nature is the Great Obstetrician and will in the majority of cases be able to pull the patient through without our "skilled assistance," therefore do not interfere unnecessarily, and do not be guilty of "meddlesome midwifery."

3rd. Remember that from start to finish in any labor case there is nothing of more importance than *asepsis*.

Here I may remark that while I am well aware that some of my friends regard this a matter of choice, or some might say useless and unnecessary, still I wish to lay especial stress upon the use of sterile rubber gloves as a routine. It has been a great satisfaction to me in my few years experience to feel sure, when finding a slight rise of temperature, that it could not be any infection coming from improper cleaning of my hands.

It is of course the duty of one who announces himself in this line of work to be ready to meet promptly all emergencies. The obstetrical bag should be kept in thorough readiness. It should contain the usual articles as sterile gauze, cotton, perineal pads.

nail brush, soap, bichloride tablets; and in addition such instruments as forceps, needles, silk or other suture material, etc.

In event of a tear of the perineum or cervix it should be repaired immediately. And before such repairs can be done they first must be found; therefore do not fail to look carefully.

Preparations are made for care of the baby before the rush, and means of resuscitation should be at hand always—hot and cold water, a flannel wrap for the child, etc.

Post partum hemorrhage always should be thought of in time to avoid it. The bladder and rectum should be emptied at the beginning of labor. Quick and vigorous kneading of the uterus, as soon as the second stage is past, should be continued through the third stage and further until the contraction is firm and a hard uterus is felt.

A routine dose of ergot after the placenta is delivered is my practice. It may save trouble and cannot do harm.

The after treatment of these cases is of importance. The duty of the attending obstetrician is by no means complete when his patient is safely delivered and comfortable. Perineal pads should be applied immediately after the patient is cleaned up and before any change of clothing and bedding. These should be used during the entire puerperal period and changed as frequently as indicated—every few hours during the first day or two and thereafter as necessary, two or three times daily. The patient should be kept quiet and comfortable in bed, not remaining in any one position long enough to allow a slight displacement to give trouble in the future. The diet should be regulated largely by the condition of the patient—the breast or rather the milk-supply being the chief index. If the milk is scanty, a liquid diet—cocoa, tea, milk, etc. If abundant and breasts are giving pain a dry diet is indicated.

The normal cases should remain in bed for ten days and should not show the least rise of temperature. The practice of giving a saline or castor oil purge on the second day is a good one and often saves a slight rise of a half or one degree in the temperature. A rise should be regarded with suspicion and if the odor of the lochia indicates the least trouble, especially if we have a chill—intra-uterine douches of hot saline solution should be promptly and frequently employed until all temperature and odor have gone.



## VARIABLE EFFECTS OF APOMORPHINE.

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FRANK K. BOLAND, M. D., ATLANTA, GA.

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Apomorphine is one of the most active and useful drugs in the materia medica, and though the ultimate effect of its administration is generally uniform, the primary effect, in my experience, is subject to considerable variation. The ultimate effect is to produce relaxation, with or without sleep. Accompanied by increased pulse rate and sweating, this may be the only effect. Usually, however, it is preceded by slight nausea and profuse vomiting, though in two of my cases it was preceded by convulsions, where none had existed before its administration.

These differences in action may be due to idiosyncrasy in the patient or chemical variation in the drug. I have seen distinctly opposite effects occur in patients, apparently suffering in the same way from the same trouble, to whom the same dose was given, and have seen a typical result, if there is such, occur in a patient to whom a tablet a year old, and black and shrunk from exposure, was given.

Apomorphine is the hydrochloride of an artificial alkaloid prepared from morphine or codeine. It is not an old preparation, and has been in common use in this section of the country for not over twenty years. The drug is recommended as an emetic, an expectorant, and a motor sedative. Dr. J. S. Horsley, of West Point, Georgia, in the Medical Record, December 6, 1890, was one of the first to call attention to its use for the last named purpose, and reported a successful cure of strychnine poisoning from its administration, without the production of emesis. Dr. Horsley since advocates apomorphine for the control of all spasms not caused by lesion of the brain or spinal cord. The drug is given hypodermically, and I do not believe it is very generally employed as an expectorant.

My observation of the effect of apomorphine, besides showing its variability, leads to the conclusion that the doses usually recommended in the text-books are too large. My dose for an adult is 1-20 grain. This will usually produce the emetic and relaxing result desired, and if it does not, it can be repeated. A dose of 1-15 grain should be the maximum, and given then only in

desperate cases of poisoning. The drug should be used only as a last resort in children.

I have never seen a death from the administration of apomorphine, but have had one case in which death seemed imminent from the use of 1-15 grain, and saw another with a colleague in which 1-10 nearly caused a fatal result. The patients in both instances were healthy, robust men. Dr. Craig Barrow, of Savannah, saw a case in which 1-12 grain caused death in a nine year old child suffering from tubercular peritonitis.

The following cases are typical of the points I wish to emphasize:

Case I. Very frail man, aged 35, steady drinker. Condition now bordering on delirium tremens, very nervous and talkative. Large doses of ordinary sedatives of no effect. 1-15 grain apomorphine, hypodermically, caused patient to go to sleep in fifteen minutes without nausea or vomiting. Pulse was slightly accelerated, and patient was in mild sweat.

Case II. Irish stone cutter, powerful, plethoric man, who got on occasional mean sprees. 1-15 grain apomorphine caused him to vomit copiously within five minutes, and break out in profuse sweat. In the midst of this, he fell over on the floor, limp as a rag, respiration very shallow, and practically without pulse. Within fifteen minutes after giving 1-30 grain strychnine, pulse and respiration had returned to normal, and he dropped off into a quiet sleep. Ever since this case, as soon as I give apomorphine, I always load my syringe with strychnine.

Case III. Married woman, aged 22. Suffering from severe epigastric pain for twelve hours, without nausea, tenderness, or rise of temperature. All other emetics proving unavailable, I gave 1-25 apomorphine, and within ten minutes she vomited a card-party meal which she identified as having taken twenty-four hours before. Afterwards she was entirely relieved of her pain, and went to sleep.

Case IV. This was a remarkable case. The patient was a very delicate man, aged 30, who had been affected with alcoholic neuritis for several days, complicated by retention of urine, for which catheterization was necessary. He was also suffering from alcoholic gastritis, and able to retain but little on his stomach. Suddenly he developed an acute and violent delirium, and it became necessary to restrain him by force. All other sedatives, in-

cluding morphine, affording no relief, I was anxious to try apomorphine, but, having just seen case II, was dubious about using it on a man in such a weak condition. Upon the advice of a consultant, however, I administered 1-15 grain. For about ten minutes this quieted the patient, without causing nausea or vomiting, and then he suddenly had a distinct convulsion, with marked opisthotonos. This continued for four or five minutes, then stopped, after which he had two similar attacks of less violence. Finally, he too went to sleep, and though sick for several weeks longer, he required no more apomorphine, and eventually recovered.

It will be seen from these cases that though the ultimate effect of the drug is constant, there are several different routes of reaching it. My conclusions in regard to apomorphine are that it is the most valuable emetic we possess, and one of the most valuable antispasmodics, but that it is a dangerous remedy, and must be used with the utmost caution. I trust the publication of these experiences will be the means of bringing out the experiences of others concerning a drug about which there yet seems something to be learned.

821 Century Building.

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## CHANGES OF DATE OF THE ATLANTA MEETING OF THE ASSOCIATION OF MILITARY SURGEONS.

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The Seventeenth Annual Meeting of the Association of Military Surgeons will be held in Atlanta, October 13, 14, 15 and 16, instead of one week earlier, as was previously announced. As judging from the present outlook, this meeting promises to be one of the most successful of this distinguished Association.

According to an announcement in *The Military Surgeon*, an ably edited journal devoted to military affairs, delegates will be present from Portugal, Ecuador, Turkey, Mexico and England.

We have no hesitation in predicting that Atlanta and her physicians will extend to the military surgeons a most cordial reception.

AN IMPROVEMENT IN THE METHOD OF DETERMIN-  
ING IF GONORRHOEAL INFECTION IS PRESENT  
IN AN INFLAMED PROSTATE GLAND OR  
SEMINAL VESICLE.\*

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BY EDGAR BALLENGER, M. D., LECTURER ON GENITO-URINARY DIS-  
EASES, ATLANTA SCHOOL OF MEDICINE, ATLANTA, GA.

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Briefly stated, the method submitted in the following note on ascertaining if gonococci are present is to create a chemical urethral discharge, and when it is well established, to seal the meatus with collodion or adhesive plaster and then to massage the secretion from the prostates of vesicles into the inflamed canal, where it is left until the patient urinates. Gonococci will proliferate if placed in this favorable invironment, and may be demonstrated in the subsequent discharge.

The importance of knowing whether or not a patient who has had gonorrhoea is free from infection, especially when he desires to marry, is so evident that it needs no emphasis. The difficulty and uncertainty that ordinarily attend the examinations before declaring such patients cured is equally well known to all who are called upon to express an opinion as to the infectiousness of these conditions. Nearly all authorities also agree that the prostate gland and the seminal vesicles are the most frequent sources of recurrent urethral discharges and reinfections. As foci of the dormant gonococcus, they are, therefore, of prime importance, and, in fact, usually the keystone of the situation in the uncertain cases.

The discharge and threads give a basis upon which to work in reaching a conclusion, especially if a discharge is produced with nitrate of silver to increase the number of the gonococci present. The condition of the prostate and vesicles is not determined, however, by this test, nor can we safely trust a negative microscopic examination of the secretion expressed from them as the micro-organisms may be in such small numbers that they will elude a most careful search—the volume of the discharge being too great to allow a smear to be made of it all. Cultures

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Read before the Fulton County Medical Society. 1908

taken from it are troublesome and unreliable except in the hands of an expert with a well equipped laboratory.

Palpation of the prostate and vesicles also affords great opportunity of making an error, as considerable induration may exist without gonococci, while a small, apparently normal, organ may contain them.

This maze of uncertainty about a condition with such far-reaching, and sometimes disastrous, results, lead me to try a plan of investigation which is both simple and easy, and when properly carried out, greatly enhances the value of the usual tests. The procedure proposed is to create any irritation of the entire urethral canal by injecting about 21 of a 1-2 to 2 per cent. solution of nitrate of silver with a soft catheter and a syringe attached, or some similar device for placing the medicine in both the anterior and posterior urethra. A few bottles of beer the night before may augment the value of the test by the irritation which usually follows. Three or four hours after the injection when the secretion has become well established, the patient should urinate and the meatus thoroughly dried and sealed with a small amount of collodion or a bit of zinc oxide adhesive plaster. The prostate and vesicles are now massaged and their secretion pressed into the inflamed urethra, where it is left until the patient is forced to void his urine.

As is only too well known, there is no better culture medium for the gonococcus than is the inflamed urethra. Naturally if the expressed secretion, which is prevented from escaping by the collodion at the meatus, contains gonococci they will proliferate when planted upon such fertile soil, even if they were more or less inactive before.

When the patient is compelled to urinate the collodion or adhesive plaster can be removed without much difficulty. This discharge is allowed to escape and the next which forms is collected, and if negative, other smears should be taken 1, 18 or 24 hours later and carefully stained for the gonococcus. If the patient cannot report at suitable times for obtaining the smears, he should be shown how to make them and provided with slides.

In applying the collodion to the meatus the lips should be pressed so that the mucous portion is slightly invaginated and the sides are in close apposition. Two or three coatings will usually be sufficient to keep it sealed. If, however, there is any difficulty,

the collodion may be applied over a small pledget of cotton, which reinforces it and makes it more secure. Only a slight burning from the ether is felt if the collodion is used without the cotton, but a little more is experienced when it is used, and may be avoided by soaking a little cotton in a 4 percent. solution of cocaine and placing it over the meatus a few minutes before sealing it. A small strip of adhesive plaster will often prove satisfactory and prevent the escape of the secretion if firmly pressed over the meatus after it has been carefully dried.

The strength of the nitrate of silver to be used must be determined by the previous treatment of the urethra. If active measures have been used a stronger solution is necessary than is required when little treatment has been taken.

This plan of searching for the gonococcus has been tried a number of times and has proved its reliability each time, whether positive or negative. From a review of the literature I have not been able to find where it has been recommended previously. Its simplicity and harmlessness and the fact that it undoubtedly enhances the value of the ordinary test make it worthy of trial.

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The Pine Ridge Sanitarium for the treatment of throat and lung diseases was formally opened July 10. The location of this institution is ideal and the equipment is all that could be desired—the “cottage tents” being especially commendable. Dr. George Brown and Dr. Louis Rouglin, have the institution under their personal supervision. We believe that such an institution will fill a long felt want and we wish for it a successful career.

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At the fourth semi-annual meeting of the Chattahoochee Valley Medical Association, Dr. C. L. Williams and Dr. J. H. McDuffie, of Columbus, Ga., read interesting papers.

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Dr. W. L. Bullard, of Columbus, Ga., has been invited to read a paper at the Pan-American Medical Congress, which convenes at Guatemala in August.

# EDITORIALS

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We will present, postpaid, on request, to each contributor of an original article, twenty (20) marked copies of THE JOURNAL-RECORD OF MEDICINE containing such article.

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## TO COMBAT FLIES BY REMOVING THEIR BREEDING PLACES.

We desire to commend most heartily the effort of Dr. Claude Smith to have the city council pass an ordinance placing a tax of \$2 on all horses and cows kept within the city limits. Practically all house flies are bred in stables, consequently it is a simple matter to exterminate them by a thorough and concerted action. The house fly never goes far from the place where it was hatched. Each citizen should therefore look out for his own premises.

The expenditure of \$15,000 to \$18,000 will be required to remove the manure from the stables of Atlanta, and it is thought by the chief of the sanitary department that a tax of \$2 for horses and cows will provide this sum.

The resolution to be introduced in council, which was gotten up by Dr. Claude A. Smith, the city bacteriologist, is along the following lines: It shall be unlawful for any person owning stables, pens, stalls, to allow them to become filthy or unwholesome. Persons owning cows, horses and mules shall be taxed \$2 per head per year. Garbage will be required to be kept in water-tight vessels, thus preventing flies. Manure shall be placed in bins or pits and covered until removed. Penalty for the violation of either one of these will be not less than \$1 or more than \$100.

The National Government is also to prosecute a systematic campaign against house flies and mosquitoes, and thus will give great encouragement to the efforts of local boards of health to exterminate these annoying and disease-producing insects.

## **SPECIAL NUMBER OF THE PRACTITIONER ON THE OPSONIC METHOD AND VACCINE THERAPY.**

The May issue of the Practitioner, London, is devoted entirely to a consideration of the opsonic method and vaccine therapy. This excellent Journal occasionally publishes a special number upon one important subject and we think the present discussion exceedingly interesting and opportune.

Vaccine therapy opens an entirely new field in medicine and one in which there is opportunity either for an infinite amount of good or harm according as the "immunisator," as Wright has appropriately designated him, is equipped for this form of treatment.

Editorially, the Practitioner takes conservative grounds and states that the enthusiast may believe that this method forms a panacea for all the infectious diseases, while another may deny that it is of the slightest value; the truth, no doubt, lies between these two extremes. It should be tried in those cases in which its use does not interfere in any way with the employment of other methods; but in those cases where surgical means are indicated, and are likely to be efficacious, there should be no delay in order to employ vaccine-therapy.

A word of warning is given to the physician unfamiliar with all of the facts, to prevent the occurrence of another fiasco similar to that which followed the introduction of tuberculin.

The first paper in this number is by Sir Almroth E. Wright, on "Some Points in Connection with Vaccine-Therapy and Therapeutic Immunisation Generally." Considerable space is devoted to the question of whether or not the opsonic index is necessary in the application of this treatment. Although admitting that when the clinical symptoms are of such a nature as to give the physician a reasonably good idea of the progress being made, satisfactory results may be obtained, as a rule, he thinks that the administration of vaccines should be regulated by the opsonic method. Much emphasis is placed upon the consideration of bringing the antibacterial agencies of the circulating blood into effective operation upon the microbes in a radius of infection.

Wells reports some "Observations on the Opsonic Index in the Infant," and reaches the conclusion that the anti-bacterial defense of the child is not dependent upon the opsonic contents of the serum.



Harris thinks, from his own experience and from corroborative evidence of other investigators, that this treatment will be recognized eventually as one of distinct value in pneumonia.

He has found that rest after inoculation is necessary for a good opsonic upward flow; active exercise on the other hand produces a sharp negative phase.

The surgeon is urged to observe the opsonic index before certain operations, especially in tubercle, and if it is low, and, time will permit, to raise it before and not after the operation if we wish to obtain rapid healing.

Inman presents an article on "The Value of the Opsonic Index in the Treatment of Pulmonary Tuberculosis," and has found that in the patient with advanced pulmonary tuberculosis the opsonic index varies widely from day to day and without apparent rhyme or reason. This is due to irregular spontaneous auto-inoculation from the focus in the lungs where the bacilli are multiplying. In such cases rest is of prime importance. Another factor of moment is to increase the coagulability of the blood by the exhibition of calcium salts. A milk diet tends to produce the same effect and he thinks this is one of the unrecognized advantages secured by the extensive use of milk in the treatment of tuberculosis. The results of vaccines in pulmonary tuberculosis are probably less satisfactory than in other conditions. Inman summarizes his paper as follows: Early or febrile cases of pulmonary tuberculosis may be treated with advantage by means of pure air and graduated exercises. When such treatment is undertaken it must be borne in mind that "tuberculin by auto-inoculation is being used." The opsonic index is a valuable guide to such treatment, and also gives useful information if inoculations of Koch's tuberculin are employed. Rest is essential in febrile cases of consumption, and in these cases, injections of tuberculin, using as a guide the opsonic index, is the treatment indicated."

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#### BILL REQUIRING MEDICAL EXAMINATION BEFORE OBTAINING MARRIAGE LICENSE.

At the regular meeting of the Fulton County Medical Society, held July 2, the Hon. L. A. Dean, of the Georgia State Legislature, addressed the society and asked its support for

a bill he had introduced this present session.

We deem this of importance to all practitioners and so present the bill for consideration.

**A BILL TO BE ENTITLED**

An act to prevent the issuing of marriage license to persons having the disease of gonorrhoea or syphilis in communicable stages and to regulate and prescribe the manner of issuing marriage license and to provide a punishment and declare the effect on the marriage contract, for the violation of the terms of this act, and for other purposes.

SECTION 1. Be it enacted by the General Assembly of the State of Georgia and it is hereby enacted by authority of the same: That from and after the passage of this act it shall be unlawful for any ordinary of this State to issue a marriage license until the male person applying therefor has made an affidavit signed and sworn to before the ordinary stating that within ten days prior to the date of the affidavit he has submitted himself to a thorough examination by a competent and reputable physician and based upon such examination and upon his own knowledge of himself he verily believes he is not the subject of acute or latent gonorrhoea or syphilis in a communicable stage, and that he has not been treated for gonorrhoea in such stage within six months, nor for syphilis within twelve months from the date of the affidavit; and shall also file a certificate made by a licensed physician of some school authorized to practice medicine and surgery in this State, stating that he has within ten days prior to the date of the certificate examined the applicant, and that such examination was made with due skill and knowledge and with sufficient time to determine whether such person is a subject of acute or latent gonorrhoea or syphilis in a communicable stage, that his professional judgment is satisfied that such is not subject to any such disease in a communicable stage, and that on professional honor and integrity he gives the certificate with a full realization of the suffering entailed upon the wife and offspring by marriage with persons having such disease. Said affidavit and certificate to be made not more than twenty days prior to the date of issuing the license.

SEC. 2. Be it further enacted, That said affidavit and said certificate being filed with the ordinary, he may issue a marriage license to the applicant provided he is otherwise qualified to

marry under existing laws; which license shall be and remain of force and authorize the marriage of the applicant only for a period of twenty days after the date thereof.

SEC. 3. Be it further enacted, That the making of a false affidavit by the applicant for license shall be ground for total divorce at the instance of the wife, provided suit therefor is brought within two years after the date of the marriage.

SEC. 4. Be it further enacted, That the making of a false certificate on the part of a physician shall be a misdemeanor, and on conviction such physician shall be punished as for a misdemeanor. That the making of a false affidavit by the applicant for license shall be false swearing and on conviction be punished as by law provided for such offense.

SEC. 5. Be it further enacted, That all laws and parts of laws in conflict herewith be, and they are hereby repealed.

The discussion following the reading of the bill was general and brought out many points. The chief of these was that the end most to be desired would not be reached by provisions presented. The general practitioner is not competent to say positively when a man is free from communicable gonorrhoea. The methods of testing for this disease are so complex and require such accurate technic that none but the specialist can be secure in his conclusions regarding a questionable case. All agreed as to this, and Mr. Dean said that the question of a Board of Examiners had been raised in the committee only to be dropped because whatever of complexity was placed in the bill would tend to defeat it and prevent any start whatsoever along this line from being made at this time.

The question of time limits arose and the members were unanimous in saying six months was too short a period after gonorrhoea to be safe.

The paragraph regarding divorce caused a brief discussion, but Mr. Dean stated that this had the approval of several clergymen, who, while they hesitated to approve of divorce on any ground, felt that the prevention of a perpetuation of a curse among the generations was the best of reasons for separation.

Finally the Society approved of the bill as it stands and agreed to make every effort to secure its passage, realizing that thereby a good foothold would be secured for further advancement scientifically and that there might be a basis for educational propa-

ganda among the people. It was particularly noticeable that the discussion turned almost entirely upon gonorrhoea and its dangers rather than upon syphilis. The horrid importance of this disease is well known to the profession, but the laity rests in grievous ignorance of its fearful menace.

It was resolved that the Society give its unqualified approval to the bill, that members do all they could personally to secure its passage; that the various county societies of the State, be communicated with and urged to support it, and that a copy of the resolution be given to the newspapers for publication.

A vote of thanks was tendered the Hon. L. A. Dean for his efforts in behalf of hygiene and for presenting the matter to the Society.

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### SOUTHERN MEDICAL ASSOCIATION.

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The next annual meeting of the Southern Medical Association will be held in Atlanta, November 10, 11 and 12, 1908, and it may be confidently predicted that this will be one of the most successful meetings of this representative and growing association. The last meeting was held in Birmingham, Ala., where the following officers were elected: President, B. L. Wyman, Birmingham, Ala.; Vice-Presidents, W. P. McAdory, Birmingham, Ala.; H. M. Folkes, Biloxi, Miss.; Frank Watson, New Orleans, La.; G. R. Holden, Jacksonville, Fla.; Raymond Wallace, Chattanooga, Tenn.; A. L. Fowler, Atlanta, Ga. Secretary-Treasurer, Oscar Dowling, Shreveport, La. Counsellors, D. F. Talley, Birmingham, Ala.; Michael Hoke, Atlanta, Ga.; John M. McDiarmid, DeLand, Fla.; W. W. Crawford, Hattiesburg, Miss.; W. W. Butterworth, New Orleans, La.; Geo. C. Savage, Nashville, Tenn. Section on Medicine, Chairman, Seale Harris, Mobile, Ala.; Secretary, H. E. Mitchell, Birmingham, Ala. Section on Surgery, Chairman, W. F. Westmoreland, Atlanta, Ga.; Secretary, J. L. Crook, Jackson, Tenn. Section on Ophthalmology, Chairman, J. F. Herron, Jackson, Tenn.; Secretary, A. B. Harris, Birmingham, Ala.

## NEWS AND NOTES

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Dr. J. E. Flowers has left for Denver, Col.

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Dr. and Mrs. W. S. Elkin spent some time at Tate Springs, and paid a short visit to New York during the past month.

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Dr. John F. Denton has just returned from a professional visit to Dalton, Ga.

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Dr. and Mrs. R. T. Dorsey have returned from a visit to Fayetteville.

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Dr and Mrs. Giddings have left for a short visit to his old home in Virginia before sailing for Europe.

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Dr. Stephen T. Barnett has returned from a recent trip to Clinton, S. C.

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Dr. and Mrs. Michael Hoke are spending several days at Wrightsville Beach.

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Dr. and Mrs. Wesley Taylor left recently for a visit to Chicago and other Western cities.

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Dr. and Mrs. Arch Avary have returned from an enjoyable stay at Wrightsville Beach.

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The many friends of Dr. Toepel will be glad to learn that he is at last able to leave his sick room and is rapidly convalescing from his recent severe spell of typhoid.

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Many members of the profession took advantage of the opportunity afforded by the mid-summer meeting of the First Congressional District Medical Society at Savannah, to visit Tybee's beach to enjoy the traditional "Savannah hospitality."

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Dr. and Mrs. Bates Block have returned from an extended tour of Europe, where they were most delightfully entertained by friends in both France and Germany.

During the third week in June the death rate in London was the lowest on record. It was only 10.8 per 1,000.

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Dr. Floyd W. McRae has resigned from the staff of the Grady Hospital and Dr. W. B. Armstrong has been elected to fill his position as surgeon.

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The Ocmulgee Medical Association convened at Cochran, Ga., July 21. After the scientific meeting, a very enjoyable banquet was held.

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The new Baptist Tabernacle Infirmary has been opened and now has sixty-five rooms, including three wards of ten beds each.

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The entire staff of resident physicians of the Grady Hospital has resigned on account of the stringent rules. The resignations were accepted and other internes were selected to fill the vacancies.

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The number of cases of appendicitis treated in the public hospitals of Prussia is said to have increased from 8,412 in 1903 to 16,781 in 1906.

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Dr. S. A. Korpff, of New York City, has been elected Professor of Phthisio-Therapy to fill the newly created chair at the New York Post Graduate Medical School and Hospital.

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The proposition of the Atlanta Medical Colleges to be admitted as part of the University of Georgia, was decided by the meeting of the board of trustees for the present, but a committee was appointed to make an investigation as to the advisability of making such a change.

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Dr. Willis Westmoreland, Dr. R. R. Kime, Dr. F. G. Hodgson, Dr. Claud Smith, Dr. Barnett, Dr. Paulin and others appeared before the Legislature and made interesting speeches in support of the bill for a state sanatorium for incipient tuberculosis.

Dr. and Mrs. E. D. Richardson are spending some time at Borden-Wheeler Springs.

The Medical profession of Atlanta and vicinity learns with much pleasure, that Mr. E. Anthony, formerly of Brannen & Anthony, has purchased the Whitaker-Coursey Drug Company's business, and in the future will conduct same at 29 Marietta street, under the name of Anthonys' Pharmacy.

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The Old Dominion Journal of Medicine and Surgery announces a change of management, beginning with the July issue. The new managers have rejuvenated this journal and have a long list of distinguished collaborators, and we wish for them success in their undertaking. We note with pride the increased interest now being taken in Southern medical journals and *pari passu* with this interest an improvement in the quality of journals.

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The following were elected by the state society as the board of medical examiners of the State of North Carolina for six years: Drs. James L. Nicholson, Richlands; Henry H. Dodson, Greensboro; Lewis B. McBrayer, Asheville; William W. MacKenzie, Salisbury; Benjamin K. Hays, Oxford; John C. Rodman, Washington, and John Bynum, Winston-Salem.

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#### STATE SANATORIUM FOR TUBERCULOSIS.

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We note with great pleasure the passage of the bill providing for a sanatorium for the treatment of tubercular patients. This bill was introduced last year by Drs. Whitely and Frye and has now passed the lower house by a vote of 140 to 14. This large majority seems particularly encouraging as the bill provides for the appropriation of \$25,000 for the sanatorium and it is sincerely hoped that the Senate will concur with the House as Georgia is in much need of such an institution.

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#### GIBBS' PRIZE ESSAY.

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The New York Academy of Medicine announced that the sum of one thousand dollars will be awarded to the author of the best essay in competition for the above mentioned prize.

The subject of the essay, as stated, shall be, "The Etiology, Pathology and Treatment of the Diseases of the Kidney."

Essays must be presented on or before October 1st, 1909.

The three subjects mentioned in the title as above given, need not be treated with uniform fullness, but new discovery or fruitful research will be considered the standard of merit.

Each essay must be in English, typewritten, designated by a motto, or device, and accompanied by a sealed envelope, bearing the same motto, or device, which shall contain the name and address of the author.

No envelope will be opened except that which accompanied the successful essay.

The Academy reserves the right, according to the direction of the donors, not to award the prize if no essay shall be deemed worthy of it.

The Academy will return the unsuccessful essays, if claimed by their respective authors, or by authorized agents, within six months.

An essay must show originality in order to obtain the prize.

The competition is open to the members of the regular medical profession of the United States.

The original of the successful essay shall be the property of the Academy, and, according to the deed of gift, will be published in its Transactions.

The essays shall be transmitted to the committee of the New York Academy of Medicine on the Edward N. Gibbs memorial prize.

John A. Wyeth, President.

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#### A FORE-CAST.

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Among the original articles to appear in early numbers of the Journal-Record of Medicine are the following: "Some Aspects of Intestinal Autointoxication, with Report of Two Cases Showing Unusual Skin Manifestations." By Dr. Lewis M. Gaines, Atlanta, Ga. "Hydatidiform Mole, (Myoma Chorion), with Report of a Case." By Dr. J. B. Cranmer, Wilmington, N. C. "Reciprocity Between States." By Dr. A. A. Kent, Lenox, N. C. "Importance of a Thorough Knowledge of Bacteriology, Bacteriology and the Circulation of the Blood for the Successful Application of Serum Therapy." By Dr. J. C. Grady, Kenly, N. C. "Report of a Case of Suppurative Leiomyoma of the Stomach." By



Dr. Whatley W. Battey, Jr., August Ga. "Abscess of the Brain." By Dr. R. G. Buckner, Asheville, N. C. "Empyema—Etiology, Symptoms, Treatment and When to Perform Thoracotomy, with Report of Cases." By Dr. John T. Burrus, High Point, N. C. "A Report of Cases Treated with Ichthyolated Emulsion Compound." By Dr. John Roy Williams, Greensboro, N. C. "Quacks." By M. A. Clark, M. D., Macon, Ga. "Chronic Stomach Ulcers; Its Surgical Treatment." By Edward G. Jones, A. B., M. D., Professor of Surgery in the Atlanta School of Medicine. "The Treatment of the Morphine Habit in General Practice." By Geo. H. Lehman.

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REGULAR MEETING FULTON COUNTY MEDICAL  
SOCIETY, MAY 21, 1908.

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REPORTED BY DR. R. R. DALY.

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Dr. E. C. Davis made some "Remarks upon Obstetrical Nursing," largely in protest against incompetent, dirty negro nurses who assume charge of patients in the puerperal state.

Dr. Archibald Smith spoke of some obstetricians who boasted of never making post-partum visits and of never using a basin of antiseptic solution. The results were deplorable, but because they were common, they were allowed to continue. He advocated a hospital, if possible, and always some trained, clean nurse to care for the mother.

Dr. Willis Jones remarked that the increased morbidity and general difficulty in cities was largely due to greater amount of gonorrhoea. He said there was an expression in France, "One child, sterility," due to the great amount of infection in that country. He advocated education of males as to the danger of old and uncured gonorrhea before marriage.

Dr. H. R. Donaldson strongly reprobated negro nurses. He related a case of laceration which he had properly dressed and left. The "Mammy" came later, removed the dressing and covered the parts with salve of her own making.

Dr. Davis, in closing, agreed with Dr. Jones as to gonorrhoeal

infection and said that 35 per cent. of post mortem morbidity was due to this cause and perhaps an equal per cent. of abortions.

He said that when there was no crisis, anybody could stay with the mother and care for her, but when the dangerous moments arrived—and no one could tell the time they would come—the negro was the very worst companion for the mother to have.

Dr. Willis Jones gave a "Review of Recent Literature of Appendicitis," which we published in full in the last issue of the Journal-Record of Medicine.

Dr. Claude Smith discussed the question of milk supply of Atlanta, and the methods in use for preventing the sale of impure milk. It is thought that tuberculosis among cows is not so frequent here as in other sections of the country. Dr. Smith urged the importance of fresh milk as the danger is greatly decreased when kept until stale. The danger of tuberculosis in milk is of small matter compared to the danger from other organisms which multiply in milk when allowed to remain warm.

Dr. Stirling asked Dr. Smith to state what per cent. of cows in this section had tuberculosis.

Dr. W. B. Armstrong said that the milk of Atlanta did not contain a large number of germs, but that a great menace was the careless manner in which milk is kept in the home and that the refrigerators usually do not maintain a sufficiently low temperature.

Dr. Hodgson said that the doctors of Atlanta were under many obligations to Dr. Smith for the excellent work he has done in improving the quality of milk.

Dr. Smith, replying to Dr. Stirling, said the percentage of tuberculosis was not accurately determined, but that the inspector from Washington has looked over a large herd of cows, and only found one cow which appeared to be tuberculous.

Dr. E. C. Cartledge read a paper on the "Treatment of Constipation."

Dr. E. G. Jones read a paper on "Gastric Ulcer." Discussed by Dr. Willis Jones and Dr. J. C. Olmstead.

Dr. W. S. Goldsmith reported the history of a patient who could not control the passage of gas from his bowels and had great difficulty in defecation.

Dr. Goldsmith also demonstrated rare specimens of dermoid-

cyst of the kidney. Undoubted evidence of a tooth and hair were found in the cyst.

Dr. Paullin had examined the kidney shown by Dr. Goldsmith, and thought there was a connection between the cyst and the pelvis of the kidney. There was only slight evidence of nephritis.

Dr. Willis Jones related history of patient peritoneal tuberculosis who appeared to be in a hopeless condition when operated upon, but most astonishing improvement had followed laparotomy.

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## BOOK REVIEWS

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PROGRESSIVE MEDICINE. A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Sciences. Edited by H. A. Hare, M. D., Assisted by H. R. M. Landis, M. D. Vol. II, June, 1908. Published by Lea & Febiger, Philadelphia.

This volume of Progressive Medicine, well sustains the reputation of this valuable quarterly. The subject of Hernia is thoroughly discussed by William B. Coley, who describes the different improvements and variations in the management of this condition. The other abdominal surgical procedures are taken up by E. M. Foote, who devotes 80 pages to this subject and reviews the recent literature. Jno. G. Clark covers the review of Gynecology in 102 pages and presents the "kernel" of the literature of the past year. Diseases of the Blood, Diathetic and Metabolic Diseases, Diseases of the Spleen, Thyroid Gland and Lymphatic system are next taken up by Alfred Stengel. The subject of Ophthamology by Edward Jackson, completes this volume.

To obtain quickly a brief resume of the year's work in any one of these fields of medicine we know of no more valuable work, and commend most highly Progressive Medicine as a conservative "up-to-date" quarterly.

**A MANUAL OF PERSONAL HYGIENE:** Proper Living upon a Physiologic Basis. By Eminent Specialists. Edited by Walter L. Pyle, M. D., Assistant Surgeon to the Wills Eye Hospital, Philadelphia. Third Revised Edition. 12mo of 451 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$1.50 net.

W. B. Saunders Company, Philadelphia and London.

The object of this manual is to set forth plainly the best means of developing and maintaining physical and mental vigor. It represents a thorough exposition of living upon a physiologic basis. There are chapters upon the hygiene of the digestive apparatus, the skin and its appendages, the vocal and respiratory apparatus, eye, ear, brain, and nervous system.

In the new third edition just issued, the work has been thoroughly revised and numerous additions have been made, including an illustrated System of Home Gymnastics, a chapter on Domestic Hygiene, and an Appendix containing the simpler methods of hydrotherapy, thermotherapy, and emmanotherapy, and a section of First Aid in Medical and Surgical Accidents and Emergencies.

An urgent need is met by this book, in furnishing a work which physicians may safely put into the hands of their patients without fear of inculcating false impressions.

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**MODERN SURGERY:** General and Operative. By J. Chalmers DaCosta, M. D., Professor of the Principles of Surgery and of Clinical Surgery in the Jefferson Medical College, Philadelphia. Fifth Revised Edition, Enlarged and Reset. Octavo volume of 1283 pages, with 872 illustrations, some in colors. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$5.50 net; Half Morocco, \$6.50 net.

W. B. Saunders Company, Philadelphia and London.

For this new fifth edition Dr. DaCosta's Modern Surgery has been practically rewritten. Some of the new subjects added are: Ransohoff's plan of dissection of the pleura in chronic empyema; Brophy's operation for cleft palate; scopolamin-mor-

phin anesthesia, local anesthesia by injection of stovain; radium; Willy Meyer's operation for carcinoma of mammary gland; Young's perineal prostatectomy; the Johns-Hopkins operation for inguinal hernia; the Quenu-Mayo operation for rectal cancer; Moynihan's short-loop method of gastrojejunostomy; the no-loop method of gastrojejunostomy, derived by the Mayo brothers; and appendicostomy. Over one hundred and fifty new illustrations have been added.

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#### SUBCUTANEOUS HYDROCARBON PROTHESIS. By F.

Strange Kolle, M. D. The Grafton Press, Publishers,  
New York. Price, \$2.50 net.

The author of this work has presented a thoroughly practical and concise treatise on the subcutaneous employment of paraffine and vaseline.

Much work has been done on this subject within the last seven years—Gersuny first advocated this method for the correction of deformities about the face, neck and shoulders in 1900. Kolle has reviewed all of the important literature bearing on this work and has thus greatly enhanced the value of his book. The author warns prospective operators against the "beauty cranks," especially those just about to engage in great theatrical ventures, circus performances and very desirable marriages. These individuals are likely to be both undesirable and dangerous patients.

A great mistake is made in the so-called rapid "filling method," without allowing the injections to accommodate themselves and to organize before others are attempted. Especial attention is given to the question of untoward results; and being thus forewarned the operator is forearmed.

Kolle unreservedly recommends the employment of paraffine in the cold or semi-solid form at the mean temperature of about 110 degrees F. He says he has used the cold injection method in 300 nose cases without a single case of sloughing, embolism or death. There are a few typographical errors, among which may be mentioned, "punctuate" for "punctate" on page 16 and "to" instead of "to be" on page 19.

## NEW EDITION OF GRAY'S ANATOMY.

Gray's Anatomy has maintained such a lead in its own field since its original publication, fifty years ago, that it has won the distinction of being the most important work in all medical literature. Hundreds of thousands of copies have started students at the beginning of their course in medicine, have been kept always at hand, and have been carried to their offices after graduation for guidance in the basic facts of medicine and surgery. Such an announcement as a new edition of "Gray" is therefore of primary importance to everyone concerned with medicine, whatever be his stage or station in medical life.

This new edition, soon to appear, is the result of a thorough revision begun two years ago. In this work Professor J. Chalmers Da Costa and Edward Anthony Spitzka, who occupy, respectively, the chairs of Surgery and of Anatomy in the Jefferson Medical College of Philadelphia, have been associated. Dr. Spitzka unites the qualifications of an anatomist of the first rank with those of an artist as well, a rare combination of powers, hence his delineations convey directly to the reader's eye his own exact knowledge of structure. He has rewritten what has heretofore been the most complex and difficult portion of anatomy, the Nerve System, illustrating it with seventy of his own drawings, so that that subject of recently revolutionized development is at once brought to date and simplified. Every other page has been scanned to reflect the latest knowledge.

"Gray" has always been distinguished by the possession of a quality defying analysis and imitation, namely, its teaching power. In this it reflects the towering genius of its author. Henry Gray died young, but left behind him this imperishable evidence of his consummate knowledge of human structure and of the best methods of imparting it to others. Nature rarely creates a Shakespeare, a Napoleon or a Crichton. Until she creates another Gray his work will stand.

No small part of the observed fact that Gray saves a student half his time and effort and doubles the permanence of his knowledge is due to its illustrations. Quantity of pictures can easily be overdone. Teaching quality is difficult to achieve and impossible to imitate. The great series of "Gray" engravings has always been unique in this essential point of teaching quality.

They enable the eye and mind to co-operate, thus focussing the whole of the reader's power on the subject before him. These graphic demonstrations simultaneously convey the terminology of anatomy by reason of the fact that the names of the parts are engraved directly upon them, whereby the nomenclature and also the position, extent and relations of each part are unconsciously and indelibly fixed in the memory. These are the four cardinal points to know about any structure, and they are conveyed by a method unique in "Gray," and one that is as simple as it is effective. Colors are abundantly used to show muscle-attachments, viens, arteries, lymphatics and nerves.

The possessor of the new "Gray" will have the best issue in which this superb book has ever appeared, and from the foregoing description it may be gathered that it will outdistance competitors by a greater interval even than before.

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## MEDICAL ITEMS

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**ALBUMINURIA:** The busy practitioner meets with many cases, in middle and advanced life, of scanty urination, with urine acidity, slight, or marked, albuminuria, and possibly some symptoms of cardiac or vascular disturbance. It is not possible, or expedient, in all these cases to diagnose Bright's disease, but, albuminuria with a falling off of the renal function is too suggestive of an approaching nephritis to justify any trifling in treatment. These cases call for the alkaline renal eliminants and a remedy like caffenio to act upon the circulation and induce diuresis. Alkalithia is such a combination and acts very promptly in the relief of such cases.

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The tension on the sutures after an operation for epigastric hernia may be relieved by placing a pillow under the knees and propping the patient up in bed.

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One should watch carefully for overdistention of the bladder in all cases of lesions of the spinal cord. In children the bladder has been known to distend sufficiently to hold 20-40 ounces.

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## RHEUMATISM DUE TO GRIP.

In speaking of the treatment of articular rheumatism, Hobarth A. Hare, M. D., Professor of Therapeutics in the Jefferson Medical College and Editor of The Therapeutic Gazette, says: "Any substance possessing strong antipyretic power must be of value under such circumstances." He further notes that the analgesic power of the coal-tar products "must exert a powerful influence for good." The lowering of the fever, no doubt quiets the system and removes the delirium which accompanies the hyperpyrexia, while freedom from pain saves an immense amount of wear, and places the patient in a better condition for recovery. The researches of Guttman show conclusively that these products possess a direct anti-rheumatic influence, and among those remedies, antikamnia stands pre-eminent as an analgesic and antipyretic. Hare, in the latest edition of his Practical Therapeutics says: "Salol renders the intestinal canal antiseptic." This is much needed in the treatment of rheumatism. In short, the value of salol in rheumatic conditions is so well understood and appreciated that further comment is unnecessary. The statements of Professors Hare and Guttman are so well known and to the point and have been verified so often, that we are not surprised that the wide-awake manufacturers placed "Antikamnia & Salol Tablets" on the market. Each of these tablets contains two and one-half grains of antikamnia and two and one-half grains of salol. The proper proportion of the ingredients is evidenced by the popularity of the tablets in all rheumatic conditions and particularly in that condition of muscular soreness which accompanies and follows the grip.

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## SOME ASPECTS OF INTESTINAL AUTO-INTOXICATION WITH REPORT OF TWO CASES SHOWING UNUSUAL SKIN MANIFESTATIONS.

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BY LEWIS M. GAINES, A. B., M. D., ATLANTA, GA.

There is no longer any doubt that the existence of indican in the urine is a positive indication of the putrefaction of protein material in the intestine.<sup>1</sup> Furthermore, excepting gross pathological changes, such as obstruction, it is known that the greater amount of these putrefactive changes occur in the caecum, ascending colon and transverse colon. It is also established that indol is a product of the activity of *B. Coli commune* exerted upon either the products of proteolytic digestion, or upon substances formed by the action of facultative anaerobes present in the intestines.<sup>2</sup>

The indol thus formed may be to a greater or less extent absorbed, oxidized and conjugated with sulphuric acid finally to

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(1) Ellinger—Zeit f. Physiol. Chemie, 1903, XXXIX, 44.

(2) Houghton—Am. Jour. Med. Sc., April, 1908.

be excreted in the urine as indoxyl sulphate (indican). Hence indican is the urinary form of indol, and indol is known to possess a degree of toxicity which varies according to the amount of its absorption, the ease of its oxidation to harmless indican, and probably according to individual idiosyncrasy, which may explain the diversity of clinical symptoms produced.

The appearance, then, of indican in the urine, we correctly assume, indicates intestinal putrefaction, and if we have associated with this certain clinical symptoms having no other positive basis, we may correctly diagnose intestinal auto-intoxication as the prominent, if not the sole cause, of the morbid condition. Chief among these clinical symptoms are nervous manifestations, such as headaches and certain forms of neurasthenia, cardio-vascular changes, muscular and joint symptoms,<sup>3</sup> eye symptoms,<sup>4</sup> skin lesions, and frequently the syndrome so often glibly explained by that fetish "uric acid diathesis."

The source and significance of indol being no longer a matter of dispute, there remains to investigate the conditions which promote its formation as well as those which influence its absorption, oxidation, and subsequent excretion.

These questions constitute the problems of metabolism which concern vitally our ability to relieve a large class of patients who in the past have been in great part treated symptomatically, and many times with indifferent success.

The formation of indol is controlled largely by two factors: first, the rapidity with which the products of proteolytic digestion are absorbed; second, bacterial activity. In regard to the first factor it has been shown that the potential indol content of a given protein may not be foretold except under given conditions affecting the rapidity of absorption of its split products, which determine whether or not the indol stage is reached. This fact bears the fruitful therapeutic lesson that we can regulate the diet so as to provide only those proteins most readily and most completely split by the proteolytic enzymes. Proteins slowly and incompletely split will naturally present in the intestine a residue consisting of a mixture of products in varying stages of hydrolytic cleavage, thus rendering absorption proportionately slow. Closely connected with this slow absorption is the matter of imperfect

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(3) The work of Dr. Michael Hoke, of Atlanta, among others is convincing of the part played by auto-intoxication in joint pathology.

(4) G. E. DeSchweinitz—*Jour. A. M. A.*, Vol. I., No. 25.

mastication of proteins, or the swallowing in bulk of milk. We may have a readily hydrolized protein but if the protein masses are large, the enzymes cannot reach their interior and a residue of great indol-producing capabilities result. Patients who complain that milk disagrees with them, frequently find they have no further trouble if they take it very slowly, as from a nipple, or by deliberately spending ten minutes in sipping one glassful.

The second factor in indol formation, bacterial activity, may to some extent be influenced by therapeutic measures. The *B. Coli* commune is a normal but not indispensable inhabitant of the colon, as was shown by Nuttall. Not only is this organism useless but it may easily become harmful whenever the protective mechanism of the body weakens. As shown above, one protective mechanism is rapid absorption of proteins, thus precluding an abundant protein pabulum for the micro-organisms. Another protective mechanism is the lactic acid formation which normally takes place in the small intestine in the digestion of carbohydrates. The acid reaction is inimical to the activity of all putrefactive organisms. This fact has, with profit, been taken advantage of in administering milk in which lactic acid fermentation has been brought about by introducing a pure culture of the lactic acid bacillus into the fresh milk, and incubating. A diet largely consisting of this sour milk has the double advantage of containing only easily absorbable protein, and of possessing this inhibiting power over protein putrefaction.

Although the diet is probably the principal desideratum, there are a group of drugs, which may also inhibit bacterial activity. These drugs do not kill the micro-organisms, but they do repress, to a certain extent, their activity. Of these drugs the most reliable are beta-naphthol, the salts of bismuth, and salol. I am confident I have gotten results from these drugs.

Concerning the factors which influence the absorption of indol we know but little. A large part of the indol formed in the intestine is excreted in the feces. It is furthermore a matter of uncertainty whether the normal mucosa can absorb an appreciable quantity of indol.<sup>2</sup> It is possible that the body not only takes precautions against its formation, but against its absorption as well. After absorption into the blood, oxidation of the indol takes place, followed by the conjugation with sulphuric acid thus changing the toxic substance into indican. This is a further protec-

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(2) Houghton—Am. Jour. Med. Sc., April, 1908.

tive mechanism of the body. We know, however, that the oxidizing of the body varies. If low, the oxidation may be incomplete, the amount of indican in the urine slight and severe toxic symptoms manifested. Hence the absence of indicanuria is not a sign of the absence of putrefaction and of the activity of the toxic indol. On the other hand a marked indicanuria may mean excessive production of indol over and above the oxidizing power of the body, hence accompanied by toxic symptoms; or it may mean complete oxidization of the indol and hence no toxic symptoms. Emerson<sup>5</sup> quotes a case with chronic constipation whose urine contained large quantities of indican for several years and yet who enjoyed the best of health. *A priori*, this is an example of complete oxidation. Should the oxidation fail, toxic symptoms would present themselves.

The practical conclusion to be drawn from these considerations is that the presence or absence of indican in the urine must be interpreted by the associated clinical symptoms and is of entirely different significance from the occurrence of other pathological constituents such as albumin. Jaffe<sup>6</sup> estimates the normal average amount of indican in the urine to be 6.6 mg. in 24 hours. Houghton,<sup>2</sup> however, maintains that this is incorrect and that there is normally no output as shown by the practical absence of indican in the urine of healthy children and of middle aged individuals under strict regimen. Emerson<sup>5</sup> states that 5.25 mg. is normally present in 24 hours. It has been rare in my **experience** to find an absence of indican, but whether or not the presence of even a small amount is normal or not, is open to question. As shown above, the absence of symptoms in cases of indicanuria may be explained by the high oxidizing power, or as Houghton further suggests because indol absorption need not extend over a long enough period for the appearance of toxic symptoms.

A not infrequent manifestation of intestinal intoxication is the appearance of various skin lesions. The following are two illustrative cases which have recently come under my observation:

**Case 1.**—Mr. H., age 21, good family history, rheumatic past history. For six or seven years with the recurring advent of hot weather the backs of both hands became livid in appearance and there was a certain amount of itching. He had had various diagnosis made upon him from eczema to Raynaud's Disease. At the

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(5) Emerson—Clinical diagnosis, 1st Ed. p. 139.

(6) Jaffe —Pflüger's Archiv., 1870 iii, 448.

(2) Houghton—Ann. Jour. Med. Sc., April, 1908.

time. I saw him the last named diagnosis was in vogue and he had been taking arsenic for a number of months. The discoloration was accompanied by slight swelling and was more pronounced the hotter the weather. For the past six or seven years it had persisted all during the summer months entirely unaffected by local or general treatment.

*Examination.*—Well developed and nourished young man, all of whose organs appeared sound on physical examination. The only point of departure from normal was the local condition. Over the entire dorsum of both hands there was a purple discoloration which faded away toward the margins to a reddish-purple, and finally to a normal flesh tint. There was no eruption of the skin, but apparently a marked venous stasis in the capillaries, for on pressure the purple color disappeared and was succeeded by a blanched area which resumed the former purple tint when pressure was removed, thus excluding purpura. There was no pain on manipulation.

The urine of the patient showed nothing abnormal except a most intense indican reaction. This gave evidence of intestinal putrefaction and so treatment was directed accordingly. The alimentary canal was cleansed and then kept clean, and intestinal antiseptics administered and a diet containing sour milk advised. The change was remarkable. In one week nearly all trace of the trouble had disappeared and in ten days the patient was perfectly well.

*Case 2.*—Mr. W., age 20, came to me complaining of a painful area over the buttocks. His family history and past history were negative except for a tendency to constipation. Physical examination revealed nothing amiss except the local condition over the right buttock. Here an area as large as a man's hand was swollen uniformly, the skin being hot and red and the surface elevated above that of the surrounding skin by at least 1-8 inch. The borders of this inflamed area were remarkably clearly defined. The appearance suggested erysipelas, but there were no general symptoms, pulse and temperature being normal and the patient feeling perfectly well. The local condition, however, caused intense burning and itching so that he was in misery constantly and unable to sit. Examination of the urine revealed an intense grade of indicanuria. The same general treatment was pursued as in Case 1, the bowels being thoroughly cleansed and intestinal

antiseptics administered. In 24 hours there was great relief, and by the third day the buttock had resumed its normal condition, except for a slight discoloration of the skin.

*Conclusions.*—The general conclusion from the above discussion and illustrative cases may be very briefly drawn. In the present light of our knowledge the types of clinical symptoms above designated accompanied by indicanuria indicate the necessity of investigating the protein metabolism of the individual. If the careful supervision of the protein ingestion and the cleansing and rendering antiseptic the alimentary tract is followed by an ameliorization or disappearance of the symptoms, we can then justly conclude we had to do with intestinal auto-intoxication and that once again rational therapeutics is firmly intrenched.

822 Candler Building.

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## HYDATIDIFORM MOLE (MYXOMA CHORII), WITH REPORT OF CASE.

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BY J. B. CRANMER, M. D., WILMINGTON, N. C.

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In writing this paper, it has not been my purpose to touch upon the histology of the chorion, nor to dwell at length upon the pathology of the Hydatidiform Mole.

I do not claim to be giving you an original treatise; this is largely a resume of the subject, with the report of an interesting case.

The degeneration, (aside from the normal process of atrophy) that may affect the chorionic villi, is of two kinds—cystic and fibro-myxomatous. This paper has to do with the first—cystic degeneration of the chorionic villi.

This pathological condition is characterized by hypertrophy of the chorionic villi, and by their conversion into cysts, varying in size from that of a millet seed, to that of a grape, or even to that of a hen's egg, connected with one another and with the base of the chorion, by pedicles of varying breadth. The ovum grows rapidly, with consequent expansion of the uterus. There is escape of blood from the uterine cavity into the vagina, and

a premature expulsion of the ovum, which is covered with small, transparent cysts. An embryo may or may not be found.

There has been much discussion of this condition, by reason of the mystery which formerly surrounded its origin. Even at so early a date as the sixth (6th) century, papers with no very clear idea of its nature, were written upon this subject. De-Graaf held that the vesicles were *mature ova*, while some authors thought that each one represented an early pregnancy.

It is probable that many of the extraordinary cases of multiple gestation recorded in the early literature, were instances of the Hydatidiform Mole, as, for example, that of the Countess of Hagenau, who was believed to have given birth to three hundred and sixty-five (365) embryo at a single labour.

Priestly goes so far as to quote, (in reference to this case), from a writer of that time: "that the Countess Margaret brought forth at one time, three hundred and sixty-five infants—one hundred and eighty-two males, one hundred and eighty-two females, and the odd one an hermaphrodite." This as late as 1276 of our era.

Pepys even records in his diary that he visited the house in which this remarkable delivery occurred, and saw the *brass plat-ter*s upon which, according to a custom of the day, the children were carried before the Bishop of the diocese, for baptism.

Numerous theories have been advanced as to the nature of the lesion, until Virchow, in 1853, stated, as his belief, that the process was essentially a myxomatous degeneration of the connective tissue of the chorion villi, and designated it as *Myxoma Chorii*.

Marchand, however, in 1895, held that the essential feature of the affection was to be found, not so much in the stroma, as in the epithelial covering the villi.

The process occurs at a time when the villi are almost equally developed over the whole ovum, before the third month, and involvement of the whole villi is the rule. Sometimes, the placenta alone is affected. In this morbid process, it is important to know, that the cells of Langhan's layer and the syncytium display an exuberant growth, showing a decided inclination to penetrate uterine tissue; therefore, the relation of myxoma of the chorion to syncytial cancers is quite intimate, and in a large proportion of the latter growths, there is associated a cystic disease of the



chorion villi. There may be metastasis of the whole chorion villi without malignant degeneration of the epithelial cells, or the chorion epithelium may undergo malignant degeneration after metastasis.

Aside from the possibility of the development of a deciduoma malignum, the hydatidiform mole is a serious affection.

Dorland, for example, noted a mortality of 10 per cent. with the one hundred instances which he collected from literature.

As I said before, the prominent symptoms associated with cystic degeneration of the chorion, are:

*First.*—A rapid increase in the size of the uterus.

*Second.*—A discharge of blood, or bloody serum, and,

*Third.*—An escape of vesicles.

This last symptom is of rare occurrence, and the first is not always typical, so that the clinical phenomena in the case of vesicular mole, do not always admit of a definite diagnosis.

None of us care to make a practice of reporting single cases, but, as few of us have an opportunity to see many *like cases*, we may be pardoned for making occasional deductions from our individual experiences.

A case which came to me a few months ago, has awakened my interest on this subject. Mrs. W., age twenty, (20); family history, negative; personal history showed previous vigorous constitution. Married ten months; menstrual period having been missed for five months. Slight hemorrhage, pain and discharge having occurred once during this period, at which time, patient was kept in bed by her attending physician, under usual treatment, for prevention of miscarriage. August 30, 1907, I was called for the first time, at twelve o'clock, mid-night, to what was reported to me over the 'phone as a "miscarriage case." Upon arriving at the house, I was told by a woman present that "it was all over." I found the patient flowing profusely, having already expelled a quantity of grape-like masses. To be sure that uterine cavity was entirely emptied, I made pressure above, and another large mass of like character was expelled. The hemorrhage was continuing to an alarming extent. Giving hypodermically 20 minims of ergotole, one-thirtieth (1-30) of a grain of strychnine, and one-eighth (1-8) of a grain of morphine sulphate, I made careful digital examination, as soon as it was practicable. The uterus was found much enlarged, flabby, and the

cervix patulous. Small particles of the grape-like masses were found adherent to the uterine walls. With lightest possible touch, and dullest rinsing curette, I went over the walls of the uterus, and washed out the cavity with a weak antiseptic solution. The hemorrhage was almost immediately controlled.

The patient made a good recovery, and is now in perfect health, although still very much impressed by the information I gave her as to the rarity of such cases, seeming rather proud of being, according to Madam Boivin, a case in twenty thousand.

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### ADVANTAGES OF EARLY OPERATIONS IN APPENDICITIS—REPORT OF CASES.

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It was my intention to read a paper on this subject before the Medical Association of Georgia, giving a review of the literature and statistics presented by the Association, thus showing the advance made in the past fifteen years, but I was unable to attend the Fitzgerald meeting.

Various opinions have been expressed in papers presented to the Association. Medical treatment has been urged as earnestly as surgical. And, if we had no other literature to guide us, it would be difficult for us to form an opinion except that the patient should ultimately be operated on. That, however, is not the point that gives us so much trouble. The great question that vexes us most, when we are called to see an acute case, is what to advise the family when asked if we believe the patient will die if not operated on.

My opinion is that every case should be operated on in the first twenty-four hours—certainly in the first forty-eight. If, however, the case is in good condition and has passed the latter of these periods, the patient will be given a better chance if the opera-

tion is postponed until the attack subsides. The resisting powers, especially the nerve centers, are greatly disturbed by the poison and pain, and to still further lower them by the operation will lessen the chances of recovery. After forty-eight hours the case should be treated medically and an interval operation urged, or if an abscess is in process of formation give time for the pus to be well walled in. Of course, this cannot be an iron-clad rule.

1. If the consent of the patient can be secured for an early operation, they can be saved much trouble, for in the first place 75 per cent. of the cases will recur, or the first attack may not subside until a relapse occurs, or it may become chronic.

2. In 904 cases operated on in Atlanta, 107 were for abscess. When an abscess results the patient is necessarily confined to the bed for a long period of time, to say nothing of the danger and the adhesions that will be carried through life.

3. Seven per cent. of these cases mentioned, had general peritonitis, of which several died, and those that recovered will also carry many intestinal adhesions to their graves and are in constant danger of intestinal obstruction.

4. The patient, in a few virulent cases, will, in a short time, be so saturated with poison that if they are not operated on and drained at an early stage, death is sure to result.

5. The patient is in constant danger of septic emboli being carried to some or all of the viscera where abscess and pyaemia, pneumonia, nephritis, endo or peri-carditis, in fact, many other conditions may develop.

6. No man, no matter how much experience he may have had, can tell what the condition of the appendix is. If the patient is in an acute attack, "who can say that there will ever be an interval? The patient may die in this attack."

Dr. Nicholson is fond of relating a case he operated on at St. Joseph's. The patient came down to the Hospital in a hack and he only operated because the patient insisted. He found the appendix filled with pus.

In two cases recently, in my own experience, at the Wesley Memorial Hospital, I have been very much surprised. Both young men. One came into my office with a temperature of 97, pulse normal. After an examination, I advised him to be operated on. After going home, coming back to town and finally

going to the hospital, where we operated, I found the infiltration extending into the colon so that we had to resect a portion of the gut. The other had "coloc," was sitting on the front porch, when I called to see another patient in the same house. I urged an operation. He got on the car and came five miles to the city, then walked to the hospital, and when we took out the appendix we found a drachm of bloody pus, an ulcer that had destroyed the mucous and muscular coats, and only the peritoneum remained; there were no adhesions and the temperature had been normal.

I fail to see why any one can oppose an early operation, when they are aware of all these and many other facts regarding the disease.

If a married woman has had one attack she should be especially urged to have an operation, as appendicitis is a grave complication of pregnancy.

To still further urge the necessity of early operations and to show how patients could be saved much time and suffering, I will report a few cases that I have operated on that were of especial interest to me.

*Case I.*—E. C. Female, age 11. Had been sick four weeks with abdominal pain, especially in right side. When I saw her, she was in a bad condition. I determined to wait, as it was a very unfavorable case. After two days, with no danger in the condition, I decided to operate and give her a chance. The abdomen was greatly distended and so tender that she could scarcely be moved. We operated on her at the house. Opening at McBurney's point, and introducing my finger, I felt a mass extending up along and behind the colon. On making slight pressure, I ruptured the abscess—fortunately near the abdominal wall, just at the upper end of the incision; the intestines were so pressed against the abdominal wall that the pus did not get into the cavity. We hastily enlarged the opening and drained the abscess. The patient was put to bed with a bad pulse, but soon reacted. After several weeks in bed, we had to make a counter drainage just below the twelfth rib. She was well in about two months, but had a large hernia where the edge of the incision had sloughed. Eighteen months later I repaired the hernia and found, much to my surprise, an appendix about 6 inches in length nearly free from adhesions and apparently normal. On making a close examination, I found one point surrounded by slight adhesions which looked like a scar. I opened it here and a small quantity

of creamy pus was present. This case is interesting for two or three reasons:

1st. The patient has been well and strong for nearly eighteen months, while there was pus in an apparently healthy appendix which was giving no trouble.

2nd. Practically all the adhesions were absorbed, even those to the scar, which was quite large.

*Case 2.*—T. A., age 15. Operated on at Wesley Memorial Hospital, 1907. Had a typical attack two weeks previous. I saw him first at East Point. He had been given a full dose of morphine a short time before and was very comfortable. There was a mass in the hypogastric region and when I examined per rectum, I found that it filled up the whole pelvis, like the head of a full term baby. He had not passed his urine well and I thought the mass might be a distended bladder. I suggested that he be catheterized and as he was in good condition, wait until next day. Early the next morning the doctor called me up and said that he had spent a bad night, so we brought him in and opened the abdomen. We found an abscess, filling up the pelvis. It contained about a pint of pus. The second or third day after the operation a fecal fistula developed and the water from an enema came through the abdominal incision. After several weeks he recovered. When he had been at home about one month he had another attack of appendicitis. We brought him back to the hospital, but as he was much better, we thought we would wait and repair the hernia that he had as the result of his abscess. I operated on him as soon as he was thoroughly free from pain and soreness. Found the intestines adhered to the scar, to each other, and to the abdominal wall. After breaking up the adhesions and removing the scar, I found the appendix in the pelvis adhered by its distal end behind the rectum opposite the second or third sacral vertebra. This was evidently the starting point of the abscess. The appendix was removed and the hernia closed and sutured with linen after the Mayo method of closing umbilical hernia. He made an uneventful recovery and is now sound and well.

In another case I operated on 48 hours after the beginning of the attack the distal end of the appendix was adherent to the abdominal wall just as in this case. The point of adhesion

was surrounded by lymph and was necrotic. This would evidently have resulted in an abscess.

*Case 3.*—Mr. W., age about 35. Operated on at the Wesleyan Memorial Hospital. He had been sick with the usual symptoms of appendicitis for the past three or four weeks, was very much emaciated, there was great muscular rigidity and a mass in the right iliac region. We opened the abdomen and found a small abscess filled with foul-smelling pus. While exploring the abscess cavity I pushed my finger through the necrotic wall of the caecum and a large amount of fecal matter escaped. This fistula continued for four or five weeks, although he improved very much in strength and flesh. His appetite was ravenous, and one day a convalescent patient gave him a lot of candy, which started what was apparently an acute attack of indigestion. I saw him a few hours after the attack began and found him in a profuse perspiration and greatly prostrated. One-fourth grain morphine together with strychnine and atropine relieved him, but the next day there was no discharge from the fistula and water from an enema came through clear, so we decided to open the abdomen again. There was much tenderness in the umbilical region, so we made a high incision to the left of the umbilicus. We found a general peritonitis, the intestines were tied up like snakes in a coil in the upper abdomen, also some adhesions in the pelvis. The obstruction was in the upper part of the tract. Some time after it was relieved the old fistula began to discharge again. The patient was in such bad condition that we had to close up without breaking up all the adhesions. The abdomen was filled with hot saline and about 1,000 cc. of saline given through the left median basilic vein. He reacted slowly and made an uneventful recovery and was well at the last report. I am not sure that the candy was the cause of the peritonitis and adhesions, but the attack coming on so soon after the error in diet leads up to suppose it was.

In other abscess cases that I have operated on, the patients, with one exception, have presented no especially interesting features.

In one case, I had a second abscess to develop in the upper part of the hypogastric regions and when opened it was apparently in the abdominal wall. There was no further trouble.

If the abscess is well walled off, the patient is very likely

to recover, but if the infection is so virulent that nature cannot wall it off in time to limit the general infection, the patient is almost sure to die.

It looks reasonable to suppose that if these had been, and many other similar cases were, operated on early, they would have recovered without so much time wasted and so much suffering.

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## ABSCESS OF THE BRAIN.

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BY R. G. BUCKNER, ASHVILLE, N. C.

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Abscess of the brain is a focal suppurative inflammation of either or both the grey and white matter.

*Etiology.*—It is always secondary and dependent upon the intracranial invasion of micro-organisms from remote sources; any one of the pus-producing micro-organisms being sufficient cause. It may occur at any age, but it is more frequent in the second and third decennial, and is very rare in very young children and in old age. It is from three to five times as frequent in males as in females. It is associated, first, with local cranial supurations; second, with injuries to the head; third, with certain general infections; fourth, with certain local diseases in other parts of the body.

According to Newton Pitt, nearly half of all brain abscesses are associated with cranial suppuration, and nearly all of these are due to middle ear disease. Chronis otitis media is by far a more common cause than the acute form. Jansen's analytical study of several thousand cases established the fact that the proportion is more than six to one; other observers have put it four to one. Other cranial suppurations sometimes follow by abscess in the causative relation are to be found in the frontal sinus, the ethmoid cells, the antrum, the orbit, and the nose and throat. Practically all cases occurring in very young children are due to trauma of middle ear disease.

L. E. Holt, in the Archives of Pediatrics, March, '08, gives the following study of thirty-two cases:

1. That abscess of the brain in children under five years is

rare; 2, that the principal causes are otitis and traumatism; 3, it rarely follows acute otitis, most often neglected cases, and is surely secondary to disease of the petrous bone; 4, in the case occurring in infancy without evident cause, the source of infection is probably the ear, even though there be no discharge; 5, the development of abscess after injury to the head without fracture of the skull is extremely rare. In nearly all the trauma cases definite cerebral symptoms show themselves within the first two weeks after the injury. In case of falls, as remote as several months, there is probably some other causes as a latent otitis.

Among the general infections most liable to become complicated with abscess of the brain are pyemia, tubercle, influenza, enteric fever, variola and erysipelas. Since pyemia is well on its way to becoming extinct, it is not so frequent a cause.

"It is of great interest that cases of abscess of the brain have been met with apart from any other macroscopic intracranial tubercular lesion which have yielded pure cultures of the tubercle bacillus."—Ballanoe.

Dr. Bristow, in 1891, published two cases following influenza without middle ear disease. Among local diseases in other parts of the body is putrid inflammation or gangrene of the lungs, suppurating cervicle glands and foci of suppuration of the liver, fallopian tubes, and at the seat wounds. An instance illustrating the last is reported by Surgeon General Turner, U. S. A., in the New York Medical Journal, March 14, 1891, of the sudden death of a soldier who was considered to be in perfect health, the autopsy showing a multiple abscess of the left frontal lobe; the man at the time of his death was reclining on a bench reading a newspaper. A few weeks previously, he had received a gun-shot flesh wound of the arm in an engagement with robbers, which had healed readily, the bone not being injured. The abscess could not be traced to anything other than the injury of the arm, though there was not a single symptom mental or physical suggesting its presence.

Brain abscess occurring after gangrene of the lung has been observed and recorded at least fifty years, though it is evident that the infection is carried in the bloodstreams, no adequate explanation as to why it should be localized in the brain has been given. In 1901, Claytor collected reports of fifty-eight cases secondary to diseases of the lungs, nearly all of which occurred



in the left side of the brain. In twenty of the cases the lung disease was bronchiectasis; in ten empyema; in nine, purulent bronchitis; in seven, gangrene; in five, tuberculous disease; in three, abscess of lung; in two, pneumonia, and in two gun-shot wounds of the lung.

Stoll reports a case of abscess in left frontal lobe and a cavity in the apex of the right lung 2 1-2 inches in diameter.

Blotche found pulmonary pigment in the pus of a vertian brain abscess.

In reference to injuries, I will only state that except when the instrument causing the injury has penetrated deeply into the brain substance, the abscess is usually really a local meningial suppuration with participation of the adjacent brain cortex, a meningo-cortical abscess rather than a brain abscess proper. Occasionally injury leads to chronic disease of the bone from which a brain abscess may arise.

*Pathology of Infection.*—Infective processes may extend from a focus of cranial disease to the interior by a visible continuous track of diseased one, or through a foramen or canal for the passage of vessel or nerve, or along the processes of dura mata which in certain situations dip into the bone, or by entering the circulation. In some injuries infected material is introduced directly into the brain or the cranial cavity, as shown by a stab culture being made. This is the only difference in the pathology of intracranial infection in case of injury and disease. The infective process spreads more or less rapidly from the spot where the dura has been brought in contact with the infested material. Here the dura becomes inflamed and extra dural suppuration occurs. This is the first state of intracranial infection, and further extension may be prolonged on account of the great resistance of the dura, and upon this depends the extent of the localized extra dural abscess. The dura may be softened and perforated immediately with only a few drops of pus collecting between it and the bone. The resistance of the dura is illustrated by Bergmann's case. On April 2nd, a man was admitted to the hospital with middle ear disease. On irrigating of the ear until it was quite free from pus, the auditory canal was rapidly re-filled to overflowing, and a mastoid operation done on March 12th. The following day, when dressing and inspecting, a fistulus track was detected. This was enlarged with a sharp

spoon. There was a recurrence of symptoms. On April 11th, a free opening was made by chisseling away considerable cone, thus freely opening the extra dural abscess. From that time recovery was uninterrupted. Pus evidently had been in contact with the dura for probably more than nine weeks, but no perforation had taken place. When the infection traverses the arachnoid, and reaches the subarachnoid space and the pia, there will be either a localized or a diffused inflammation, the extent depending on the virulency of the infection.

The infection in disease of the cranial bone is by direct continuity in the continuous track of diseased bones. In a rapidly extending infective process, diffuse meningitis would be the most probable result; in the more slowly spreading infections resulting from chronic disease, the meningeal affection would be localized by adhesion, and time given for extension of disease of the brain. This is shown by the fact that abscess of the brain or sinus infection is more common complication of chronic ear disease than is acute suppurative meningitis. In most cases of slowly spreading infection from chronic disease, adhesions occur obliterating the arachnoid space at the site of infection, and binding together the dura, arachnoid, pia, and cortex. The lymphatic shields of the numerous small blood vessels which traverse the cortex at right angles to its surface, are in direct communication with the subarachnoid space, and through these as through a number of capillary tubes infective matter easily traverses the cortex and reaches the white substance. The cortex is very vascular, and its connective tissue element is reinforced by numerous folds of promulgaion from the pia, and abundantly supplied with the connective tissue corpuscles, hence, it is able to offer a strenuous resistance to the bacterial attack, and does not usually undergo any extensive material, a barrier of fibrous tissue is formed, limiting the destructive process to the narrow track.

The white substance is much less resistant, because it is non-vascular, and the greater the distance from the cortex, the more easily does the bacterial action cause its dissolution. In its incipency it presents the local appearance of what has been described as acute red softening; the degree of redness depending upon the amount of blood determining to the point. As it advances, the pus changes from a reddish-yellow to a greenish, or greenish-yellow color, and in some cases the odor is quite of-

fensive. This abscess comes to assume a mushroom shape with the stem attached to the dura at the original site of infection from the bone. When the dura has been separated from the bone over a considerable area, there is a greater extent of adhesion of the meninges. Salzer successfully operated on a case where the temporo-phenoidal dura was separated from the bone over an area as large as a silver dollar, and was in a sloughy condition. The sloughing portion was excised and the meninges were diffused into one layer; the inner portion, formed by the pia, was not necrotic, and there was no abscess of the brain.

Mannasse reported a case in which the infection had proceeded further, and there was abscess of the brain, the outer wall over which a considerable area was formed by fused meninges and cortex. The more recent the abscess, the nearer it will lie to the spot where the infection traversed the dura, and the more evident will be the stalk, or its remains. The older the abscess the greater is the apparent recession from the dura, and the less evident the stalk. Thus the infection gradually spreads into the brain substances by slow extension in direct continuity from the spot where the disease in the bone reached the interior of skull. Yet infective particles may, in the brain, as in other parts of the body, be carried by circulation to a spot remote from the site of infection. An abscess may thus arise in the substance of the brain without any visible connection with the bone disease to which it really owes its origin. The stalked form of brain abscess compares in its mode of formation to palmar abscess, from which infection in an abrasion of the skin of the palm, being connected with the superficial area by a narrow tract to a focus of disease beneath the deep palmar fascia, and the isolated brain abscess has its parallel in an abscess of liver arising from disease of the intestine.

The explanation of the pathology is not far to see in a case reported by Swain, in which purulent infection of the choroid plexus in the descending cornu of the lateral ventricle occurred as a result of caries of the tegmen tympani of the same side, the intervening brain substance being unaffected. In rapid increase of the abscess it may lead either into the ventricles or on the surface of the brain.

Encapsulation of abscess in the brain is thought to be relatively more frequent than in other parts of the body. The

pathological process is the same, but the peculiar liquid texture of the brain allows a sharper differentiation between the hard tissues forming its wall, and the surrounding unaltered brain substance. Acute brain abscesses are sometimes encapsulated, and nearly all chronic abscesses are encapsulated.

In a case of cerebellar abscess, with symptoms pointing to a duration of at least eight months, no capsule is found, but the whole cerebellar hemisphere was nothing but a shell of softened gray matter. As in other parts of the body, the latent abscesses may slowly extend and give rise to slight symptoms extending over a considerable period, and encapsuled. A slowly growing abscess may be regarded as pushing aside fibres passing from the cortex to the internal capsule, rather than destroying them. This inference is supported by the fact that recovery from paralysis takes place after successful drainage of the abscess, yet it should be remembered that cortical impulses may find new paths.

When an abscess is drained through the stalk, as in the case of temporo-sphenoidal abscess opened through the tegmen, though it may be large, there may be but little actual damage to the cortex. A thick capsule does not prevent the abscess from extending, nor even from leaking into the ventricle. It is a fact also, that acute inflammatory softenings, or even suppurations, have been known to arise around an encapsuled abscess. Abscesses in thick capsules, which can be shelled out whole, have run a chronic course. Complete encapsulation of the stalk form does occur, the narrow track of communication being obliterated by scar tissue. In such cases the capsule was found to be adhered to the bone.

When an abscess is found in the brain completely isolated, and at some distance from the meninges, the infective organism has been carried by the blood or lymph stream, and has multiplied at a spot some distance from the original point of infection. Many such cases have resulted from injury without bone disease, a considerable number having followed gun-shot wounds. The complications usually found are phlebitis and thrombosis of the lateral and the superior petrosal, sinus leptomeningitis, extensive meningo-encephalitis, and purulent pachy-meningitis, leptomeningitis and sinus thrombosis being especially common in cases of aural disease.

*Streptococcus pyogenes albus*, *staphylococcus cereus flavus*, and the bacterium *vulgarius*, Charcot and Leyden crystals and streptothrix, have been found in pus from cerebral abscess.

Spontaneous recovery in certain tubercular cases have been cleaned by competent observers. Inspissation, and even calcification of the brain abscess has been observed, but only in tuberculous cases. It is stated by Ballance that cases are relatively common in early life, which either get well or turn a chronic course, extending over many years, and then die from distention of the ventricles; and the only explanation of the symptoms can be given by inferring the presence of cerebral tumor, or of meningitis. In these cases it seems probable that there was a local tuberculous mass in the brain from which recovery had come. In one such case some four years after a diagnosis of cerebral tumor had been made, the autopsy showed great distension of the ventricle. There was no visible tumor, and no evident trace of tubercle in the brain. But in the mesentery there was a large calcareous mass.

Two girls under twenty years of age both suffering from headache, vertigo, nystagmus and repeated purposeless vomiting; both had double optic neuritis, unsteady gait, and absence of the patellar reflex. The diagnosis in both cases was some affection below the tentorium, probably tumor; both made good recoveries, but in one, some impairment of sight remained.

Abscess of the brain is commonly single. MacEwen says 93 per cent. of abscesses from injury are single. In pyemia they are usually multiple. A second abscess occurs in the frontal and occipital lobe occasionally, and even more often in the temporo-sphenoidal lobe.

*Symptoms.*—These may be broadly divided into general and focal symptoms. Among the former are headache, photophobia, slow cerebration, slow pulse, subnormal temperature, occasional chills, foul breath, deathly pallor of the skin, constipation, facial palsy of the peripheral type, optic neuritis, impaired vision, conjugate deviation of the eyes, stable pupil, nystagmus. The mental state is very likely to be mistaken. In order to estimate exactly it is well to know the mental capacity of the patient. A condition of excitement and talkativeness in a person who is reserved and stolid, is of much more importance than in an excitable and loquacious individual. Also apathy and delirium in a man of bright active intelligence is of greater diagnostic value than in one who is dull and stupid. These variations in the mental state are observed also in a sinus thrombosis, meningitis and tumor.

Headache is a variable symptom, there being few cases recorded in which it was never noted, and other cases in which it was not a very marked symptom until late in the disease, and still other cases in which it occurred at different times, but was never severe, and still other cases in which it was the chief symptom.

The course of the temperature is also quite variable. MacEwen points out that it is common in abscess of the brain to find a persistently low temperature with little variation, and that during the preliminary period it is usually slightly above normal. During the period of full development of the abscess, it is about normal, or slightly subnormal, from 97 to 99 F., and in the terminal stage if the abscess burst the temperature rises within a few hours in a bound to 105 F., but if it is evacuated by operation, it rises to about 101 F., and in a few hours falls below 100 F., remaining around normal until recovery. Okada found a marked rise of temperature and febrile course in forty-six out of eighty-eight cases of abscess of cerebellum. In fifteen the temperature was normal, and in fifteen it was subnormal. In eight there was a rise of temperature only at the onset, and in four only at the very end.

Rapid emaciation, the cachectic appearance, with sallow skin and evidences of the septic state, and other above described symptoms, suggest latent abscess.

Optic neuritis is a valuable sign when taken with other symptoms. In Okada's cases, two-thirds of his patients had optic neuritis in one or both eyes. In groups reported by other observers, it occurs in 30 per cent. of the cases, but it occurs also in brain tumors, meningitis and sinus thrombosis.

The following localizing symptoms should be taken into account: ( Motor aphasia, optical aphasia, hemianopsia, hemianesthesia, and weakness of the arm and leg, vertigo, ataxia, with purposeless vomiting, lying prone on the side of the lesion, or falling toward the side of lesion, etc.

Careful observation and record of the case for a sufficient period of time should be made. In this way an undoubted diagnosis may be made in most cases. Yet a few diagnoses will remain to be made post-mortem. There is wide difference in the clinical course of cases on account of the suppurative process varying within the wide limits in its virulency and local destructive effects. Five types of clinical evolution have been described

by French authorities. 1, a sub-acute evolution more or less distinctly divided into three stages, with an initial febrile stage characteristic of septic infection; headache, vomiting and fever. This state may be confused with specific fever. It lasts a variable number of days, and is the state of suppuration. The second state is that of remission, sometimes suddenly, but more often gradually, the symptoms abate and give place to a calm which is deceptive and prolonged; and during this stage there are few or no manifest symptoms. Yet, when the abscess is in the cerebellum, there will be some emaciation and impairment of the general health, and thorough examination would reveal some pathognomonic localizing sign. The third, or paralytic state supervenes suddenly, with or without convulsions. This may pass into profound coma, terminating fatally in a few hours, or recovery from the convulsive seizure may take the place of symptom localizing the lesion. With the onset of the third stage is generally a rising temperature. The rapidly fatal cases are usually from rupture of the abscess. The others have a more or less rapid extension of the suppuration.

See Starr, page 571, describing case of middle ear disease.

2. Evolution with severe general infection.

These cases are rapidly fatal, the abscess symptoms begin merged into those of grave general infection. High fever and delirious mania are prominent symptoms

3. Evolution with complete Latency until the final attack or coma, the patient dying suddenly or in a few hours, and an abscess that has existed usually for a long period is found at the autopsy. In some such cases death is absolutely sudden. The abscess in such cases may be found in the frontal lobe or in the outer region of the occipital lobe, and even more frequently in the right temporal lobe. In these silent cases an examination of the optic nerve head, the field of vision, and the action of the muscles of the eye has revealed the gravity of an illness which has been regarded as trivial.

4. In the fourth type of clinical evolution, the course is just like that of brain tumor.

5. The fifth type of evolution is remittent, the course being in two acts. The first is marked sometimes by headache and fever, sometimes by an attack of mania, and sometimes by acute delirium; then all quiets down and the patient seems cured, but

after a few weeks or months, or even a year, there is a recurrence of symptoms which is quickly fatal. Bristow's influenza cases previously referred to, are examples of this type of evolution. In localizing the abscess the position of the injury causing, or the cranial suppuration from which it originated, have some bearing.

Unilateral spasm, paralysis, hemianopsia, and aphasia, are important symptoms in determining the exact location of the abscess. In locating temporal abscess a certain form of aphasia that has recently been observed promises to be very helpful. The memory centers for hearing are located in the first and second temporal convolutions. The relative degree of development of these vary in individuals of different degrees of education. The memory centers of sight are located in the angular gyrus and calcarine fissure. The centers in these two areas are connected by association fibres passing through the white matter beneath the cortex. Deep abscess in the left temporal lobe destroys or displaces these fibers, preventing communication. If you say the word "knife," the patient can repeat it, but cannot form any notion of what it represents any more than from a word of a foreign language. If you show him a knife he can say it is what you cut with, but he cannot recall the word knife. This is called optical aphasia, or intercortical sensory aphasia. By this symptom diagnosis of abscess in the left temporal lobe was made and verified by operation. In any suspected case this symptom should be looked for, but it is useful only in locating the abscess on the left side of right handed people, and in the right side of left handed people.

Conjugate deviation of the eyes shows irritation when toward the side of the lesion, and paralysis when from the side of the lesion.

*Diagnosis.*—The diagnosis of brain abscess may be made without great difficulties in ordinary traumatic cases, for there is history of the injury and the exact location and development of a series of cerebral symptoms pointing to localized disease in the brain. Nervous symptoms coincide with the location of the wound, and the localization of the cerebral disease, and the existence of the abscess is reasonably certain. When there is no history of an injury the diagnosis is more difficult, because acute tuberculosis give the same symptom complex. Cases of brain abscess from otitis media must sometimes be distinguished from



meningitis and thrombosis of the lateral sinus. The relative frequency of these conditions are not far from the same.

Poulen collected thirty-six cases of cerebral complications of ear disease. Thirteen of these were abscess, twelve were thrombosis, and eleven meningitis, there is usually a more rapid onset and progress of the symptoms than in abscess. The headache is more severe. There is hyperesthesia to sound and light and touch all over the body, these being absent in abscess, the temperature is high and rarely ever goes below normal. The pulse is rapid, irregular and intermittent. There are occasional twistings of the limbs, or slight convulsions; strabismus appears early, trismus is common, pain and rigidity of the neck are present, micro-organisms are to be found in the cerebro-spinal fluid.

In thrombosis of the lateral sinus, there will be high fever, with septic variations in range, and frequent chills. In the course of twenty-four hours the temperature may twice sink below normal and rise to 105 F. The pulse is rapid and irregular, but not intermittent. There may be tenderness, swelling and edema over the mastoid, and edema of the neck. The jugular vein may stand out as a hard, blue cord on the side of the neck.

The diagnosis of abscess arising under other conditions is never positive. The presence of a cause, and a record of cerebral symptoms that occur in a definite series of stages point strongly to presence of an abscess.

*Prognosis.*—This will depend upon the possibility of evacuating the abscess and draining it successfully. Spontaneous recovery has been recorded, but this is so rare as never to justify waiting.

Necrosis and caries of the tegmen was so great in one of two cases of temporo-sphenoidal abscess as to allow them to spontaneously drain freely and successfully. This occurred just as it has done in a few cases of suppurating appendix. Star reports a collection of fifty-five cases operated. Twenty-four were after injury, twenty-four after middle ear disease, and three after typhoid. Thirty-four recovered, and twenty-one died.

In a group of sixty cases of traumatic abscess operated, thirty-eight recovered, twenty-two died. In a collection of one hundred and ninety-six otitis abscesses operated, ninety-six recovered.

Dunch operated on nine cases and three recovered. Barnhill

operated on eight cases, two of which were alive and appeared to be cured four years afterwards, and one of the others died of a recurrence four months after the operation.

One swallow doesn't make a summer, and even if death followed every operation in a *small* group of cases, who could have the temerity to question the true spirit of surgery in an effort to evacuate and drain *all* of them.

As far back as July, 1905, Korner reported ninety-two operations with fifty-seven recoveries, and twenty-nine cases of sinus thrombosis with forty-one recoveries. It is more than probable that part of the cases in which recovery does not occur, the operation had been too long delayed, or was not sufficiently exploratory.

*Treatment.* 1.—General considerations. An abscess in the brain should be dealt with just as with abscess in other parts of the body, that is, by incision and thorough drainage, and if encapsulated, emucleation.

In operating, the surgeon must find out as he goes its situation, and whether acute or chronic, diffused or circumscribed, or whether there be a second one. A case of acute cerebellar abscess, opened with relief to the symptoms, died and at necropsy an old encapsulated abscess was found still further in.

When the abscess is drained, the brain tissue, which is of liquid texture, tends to fill the space, and shut off a portion of the cavity from the point of incision.

The integrity of certain parts of the brain are essential to the continuance of life, and places a limit to surgical interference in certain directions.

These general considerations do not affect the principles of treatment, but have important bearing upon the details of the operation.

2. *Operation for Brain Abscess following Local Cranial Diseases.*—The operation for brain abscess should be a direct continuance of that for the removal of the continuous tract of diseased bone through which the infection spreads. This track must be followed through the bone to the interior of the skull.

If, after a mastoid operation, or Stake's operation for necrosis of bone in the tympanum, the symptoms point clearly to abscess in the cerebellum, or temporo-sphenoidal lobe, the surgeon should work his way, in the one case from the inner, or posterior

wall of the antrum to the posterior surface of the petrous, or through the roof of the tympanum.

Enough of the petrous and squama must be removed to expose the extra dural abscess, or the diseased portion of dura to which the brain abscess is attached by its stalk. By this method it is known whether the abscess has a stalk, or is isolated. This stalk is a ready-made drainage tube, and is less liable to be closed from the liquid consistence of the brain than one made by the surgeon, also infection of the meninges is far less likely, as well as hernia cerebri.

In cerebellar abscess, the stalk is attached to the dura over the sinus groove, or over the aque-ductes vestibuli, or over the internal auditory meatus. In temporo-sphenoidal abscess, it is over the anterior surface of the petrous, most commonly over the tegmen.

Frontal abscess is attached to the cranial wall of the sinus, or the anterior surface of petrous.

In deep abscess following an injury the stalk is attached over the region of the fracture. Drainage through the stalk would remove the symptoms and tendency to death, but there are cases that will require a counter opening, as in other parts of the body. To do this, remove a considerable area of bone, *open the dura* and pack with gauze until this area of the brain for incision is walled off by adhesions. This avoids diffuse encephalitis and meningitis. The area of bone removed should be in proportion to size of abscess as determined by probe through the stalk.

If respiration ceases the abscess must be evacuated in the shortest time and easiest way, and the local bone disease let alone for the time being.

Mr. Ballance, on two occasions completed the operations during the performance of artificial respiration made necessary by the first few inhalations of chloroform. Also in another, in which artificial respiration had been in progress two hours before he arrived. And he insists that neither morphia nor strychnia should be administered before the dura has been opened.

3. *Discovery and Incision of Abscess.*—The abscess may burst when the dura is opened, and pus may be projected more than two feet. When sufficient opening through bone and dura and bone is made, palpation may show it to be immediately subcortical. Incision through the cortex may be made, with great care to avoid

wounding any of the numerous vessels. The best instrument for exploration is a sharp pointed, long, narrow knife, and it should be borne in mind that the abscess is nearly always close to the bone disease giving rise to it. Clean cut wounds heal quickly, and it is easier to find the abscess with the knife.

The trocar and canula have missed the abscess, or passed through without tapping it, or struck the capsule and failed to penetrate it. Dupuytren, in one of his lectures, says: "In certain cases of deeply seated fluid collections, we must incise the dura and arachnoid and brain itself, and by this bold proceeding, patients have been saved." In the same lecture further on he continued: "Relying also on the success of J. L. Petit, Boyer concurs in the advice of Quesnay, and does not fear to plunge the bistoury quite deeply into the very substance of the brain in order to evacuate traumatic effusions, and it has fallen to my lot several times to do so with success." Fifty years later an English surgeon wrote: "There are few surgeons who would have the hardihood of Dupuytren, who plunged a bistoury in the substance of the brain, and thus luckily relieved the patient of an abscess in this situation." In his account of this, Dupuytren says: "I incised the dura, nothing came out; I thrust the bistoury cautiously into the brain and there welled up immediately a flood of pus! That very night all the symptoms disappeared, and the patient recovered." If the knife failed to find the abscess, it is quite easy to find it with the finger, as a tense, abnormal swelling, which may be opened by the knife guided and guarded by the finger. A second abscess may be mistaken for the teutorium.

In two cerebellar cases, one abscess in one and two in the other, were drained, and yet both patients died from an unopened, oyster shaped abscess just beneath the cortex of the upper surface.

*Progress of the Case.*—The course of brain abscess is variable. The earlier the operation is done the greater the chance of recovery. There should never be delay after diagnosis is made, and the operation should always be done unless the patient is actually moribund.

The operation has been done during artificial respiration and the patient recovers.

After the operation the patient may rapidly convalesce, or present symptoms which will tax to the utmost the resources of the surgeon. A voracious appetite is a favorable sign.

Less than a generation ago but few surgeons ever attempted to operate for brain abscess. During the last twenty years recoveries achieved make the future of this field bright with promise.

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### REPORT OF A CASE OF SUPPURATIVE LEIOMYOMA OF STOMACH. HOUR GLASS CONTRACTION OF SAME.

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Mrs. B., age 62, occupation housewife. On January 26, 1907, patient complained of lassitude, loss of appetite and constipation, temperature 102 1-5 degrees Fahrenheit. She was seen by Dr. Battey, Sr., who administered a cathartic and put patient to bed on a liquid diet. Condition was regarded as one of autotoxemia. After bowels moved freely abdominal distention and tympany was materially relieved. Temperature touched normal. Patient was up and around third day following visit. One week after first visit patient had a relapse, was put to bed and treated for original conditions. Stools at this time were very offensive, temperature ranged 100 in a. m., between 102 and 103 1-5 in p. m. At times a. m., temperature was normal. For several days afternoon temperature touched 99 degrees. Abdomen was very much distended, pulse ranged from 100 to 120. Absence of nausea or vomiting, no tenderness or abdominal rigidity.

Condition was thought to be typhoid. Diazo reaction negative. Widal negative. Haemoglobin estimate 75 per cent.

I was called in consultation on February 22, 1908. The general make up of patient to me was typhoid, though she had never had, nor did not present rose-spots. On morning of February 23, on palpating abdomen, I discovered a mass in epigastrium which was movable, but owing to marked distention the exact location of growth was somewhat confusing. Owing to cachectic appearance of patient and presence of mass, I advanced the diagnosis of cancer of intestine, stomach omentum or transverse colon. At another examination of abdomen I did not find mass first felt,

and I was inclined to believe it to have been a foecal accumulation in transverse colon. At a third examination of abdomen I felt the mass distinctly and was thoroughly satisfied with diagnosis.



Longitudinal diameter of tumor, 3 inches; cross diameter of tumor, 2 inches; cross diameter mid points of stomach, 3 inches; length of stomach, 10 inches, (from pyloric to cardiac orifice); pyloric orifice, 2 inches.

Several other consultants were called in, who in the presence of marked abdominal distention could not locate mass and agreed that symptoms were typhoid, owing to fact that 1 to 20 Widal done by Dr. Levy was positive. Leucocytosis by Dr. Wood showed 32,000. Later by Dr. Levy, 18,000. Tests of urine for indican, albumen, sugar or casts negative. Patient took nourishment without least trouble. Bowels were inclined to be constipated. Stools very offensive. The use of various forms of intestinal antiseptics having little effect upon odor. Patient passed into state of coma and remained so for four days before death.

Autopsy revealed following finding: Hour glass contraction of stomach with pedunculated tumor situated just below oesophageal entrance. The same having several sinuses, discharging thick creamy pus. The descending colon contained a growth of similar size, and throughout its whole course was reduced to one-half normal size. There was no evidence of disease of small intestine.

Measurements of tumor and stomach as follows:

Longitudinal diameter of tumor, three inches. Cross diameter of tumor, two inches. Mid point of stomach, three inches. Length of stomach, ten inches from pyloric orifice to cardiac orifice. Pyloric orifice, two inches.

*Pathological Report by Dr. Oertel: Leiomyoma.*—The death of patient was caused purely by septic absorption. The offensive character of the stools was due to putrefaction owing to the fact that tumor in descending colon had partly sloughed away. At no time of her illness did she complain of nausea nor did she have any gastric disturbance. This seems almost incredible when we observe that pus was being constantly discharged into stomach from tumor. The high leucocytosis can be accounted for the in presence of pus. The positive Widal shows that such would be considered merely as corroborative evidence in typhoid. According to Green, Leiomyomata occur in the stomach and oesophagus, but they are rare in former location. The case was considered a medical one throughout, owing to extreme condition of patient, it being hoped from day to day that her condition would improve and permit of an exploratory laparotomy.

## POST-GRADUATE STUDY IN EUROPE.

WITH SPECIAL REFERENCE TO EYE, EAR, NOSE AND THROAT.

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Post-graduate study in the various medical centers of Europe has long had ardent advocates among American physicians, but it has been only in recent years that they have in any great numbers forsaken their own great cities for foreign study. The change has been brought about by a number of causes, probably the greatest of which is the tendency of the profession to specialize, along all lines, the inadequacy of American courses and scarcity of practical teaching in special branches. In our post-graduate schools and hospitals the specializing physician, who is unwilling or unable to take service upon the house staff of some special hospital, can usually obtain no teaching and practice beyond that prepared for the general practitioner by the post-graduate schools, and special hospitals pay little or no attention to clinical and practical teaching. A number of such special institutions advertise "unexcelled clinical advantages and teaching," but the student generally finds that after paying his fee in the office he receives no more attention, and is looked upon rather as an intruder. The advantages are here most certainly, but they are not for the student, and the teaching is conspicuous only by its absence.

Of course it is possible for some to find clinics in which minor positions upon the attending staff may be obtained for the asking or for money, but only a favored few have this good fortune, and it may take months of search and waiting to find a satisfactory appointment.

Heretofore many Americans have been unwilling to go to Germany and Austria for special work, because they considered a knowledge of the German language essential, but of late years they have learned that courses on any subject in the medical line can be obtained in English in Vienna, and to a lesser degree in Berlin. Not a word of German need be learned for the successful prosecution of a course of study in Vienna.

Again, the sharp reduction in rates caused by the struggle for patronage between the English and the German transatlantic



steamship companies has drawn an unprecedented number of Americans to Europe within the past year. In Vienna alone, in November, 1907, there were over two hundred American physicians, and other medical centers had correspondingly large delegations.

The advantages of European study are many. Granted, for the sake of argument, that its advantages are only equal to those offered by our own hospitals, the prestige alone of work abroad is well worth the trip. But, aside from this rather unworthy consideration, European hospitals actually offer more in the same length of time, more systematized work, more thorough work for the student, and at less cost, than American hospitals.

A great objection to practical work in our hospitals is that no clinics whatever are held in the morning, except those in the regular post-graduate schools, and the practitioner, who is generally at heavy expense both at home and at his place of study, is obliged to waste half a day every day before getting any work. Of course this may not apply in every city, nor to every specialty, but it is certainly the general rule. The American physician in a large city must have his office hours in the morning, and therefore cannot hold clinics during that time. In Europe the physician has his office hours at a time which will not interfere with his clinic, and consequently a student can attend clinics there from eight in the morning until eight or nine at night. The amount of experience to be gained is limited only by one's endurance.

London offers splendid opportunities for general work, diseases of children, skin, G. U., opsonic work, and eye. The skin clinics there are immense, and it is probably the best place in the world to study this specialty. Genito-urinary work is also excellent, and there are unusual and numerous opportunities for observing prostatectomies. There is good clinical and practical instruction in diseases of children here, and the clinics are large. For the embryo oculist, who has done no previous work in this line, Moorefield Eye Hospital (or Royal Ophthalmic Institute), London, offers splendid advantages. Every student who is enrolled here is called a "Junior Assistant," and, after five month's work is given a certificate stating that he has served a term as such, and has enjoyed the advantages of the "practice of the Hospital." Systematic courses are given here four times a year, beginning on the first of January, April, July, and October, upon refrac-

tion, operative work on pigs' eyes and the cadaver, external diseases, examination, muscles, pathology, ophthalmoscopy, etc. These courses contain from four to twelve lectures or lessons each, and are spread over the term of three months. Those on pathology under the famous English pathologist, Parsons, and on ophthalmoscopy, illustrated and demonstrated by over a hundred patients with pathological fundi for the student to examine, are especially good.

The student at Moorefield signs up with two of the chief surgeons, reports each morning for duty from nine to one, is given clinical demonstrations by the surgeon in charge, refracts, examines patients, perhaps does a minor operation or two, and studies what pathological fundi there may be encountered in the day's clinic. He does not live in the Hospital, nor does he wear a uniform, and he is free in the afternoon to attend clinics in other hospitals. Ear, nose, and throat courses are not satisfactory in London, and those offered at Gray's Inn Hospital and at Golden Square Hospital, which are the best, are too elementary for anyone save a novice.

Paris offers no inducements for post-graduate work, and is generally passed up by the American student, except when on pleasure bent.

Berlin has been the favorite medical center in days gone by, when only German-speaking Americans studied there, but it has yielded first place to Vienna since the surgeons of the latter city have made a specialty of giving courses in English. In Berlin an American is seriously handicapped in his studies if he does not speak German, and it is often necessary to spend several months studying the language there before he can make any progress at all in his work, although some of the courses are given in English. There are many hospitals here, and they are situated in different parts of the city, necessitating quite a loss of time to the student who cannot arrange for all his work in one hospital.

The Anglo-American Club of Berlin will be found of great assistance to the American stranger.

Vienna should be the Mecca of all Americans seeking post-graduate medical work, for here the student can get courses in English upon any subject, under world-famous men, and the work is all concentrated in the immense "Allgemeine Krankenhaus," containing three thousand beds, and the smaller "Polik-

linik," only a short block distant. Here the surgeons in charge of the clinics make a specialty of speaking English and giving post-graduate instruction to Americans, for doing which they have been accused by their brethren in Berlin and London, of "selling themselves to the Americans."

The courses here are given under the supervision of the American Medical Association of Vienna, which looks after newcomers, helps them to begin their work, to find rooms and pensions, regulates as far as possible the number of students in each course, and by co-operation with the professors assures each one fair play. This excellent organization holds regular, well-attended meetings in an amphitheater of the "Allgemeine Krankenhaus," and publishes, for the benefit of the strangers, a complete list of all courses usually taken by Americans, announcing the time, place, fee, duration and number of places of each. Also, by its efforts these courses have become affiliated with the University of Vienna, and after taking a certain number of them during a stay of not less than three months, a post-graduate certificate is issued by the University, if so desired.

Vienna courses generally last about twenty hours, one hour each day except Sunday, though some are shorter, and some longer. They are usually limited to eight or ten men, and are repeated as often as the minimum number signs up on the list, which is posted on the notice board of the American Medical Association, at its headquarters in Cafe Klinik. During the Winter the most popular courses are often signed up for six or eight weeks in advance, but others on the same subject are always being arranged, and a new comer can rely upon being at work in full blast within a week after his arrival. Six or eight courses at a time will give even the most enthusiastic worker all he can attend to, and leave scant time for clinics, which occur at all hours of the day, but chiefly in the morning, the afternoon being largely given over to teaching.

The work in these courses usually consists of lectures and demonstrations upon the anatomy, physiology and pathology of the parts involved, operative work on the cadaver, and clinical demonstrations. Operative work on the living can also be gotten in some branches, but it is very expensive.

In diseases of the eye, ear, nose, and throat, there were, during the fall and winter of 1907-1908, almost as many stu-

dents as in all other branches combined. Especially good is instruction in all branches of diseases of the eye, except refraction; not many Americans attempt to refract in Vienna. In ophthalmoscopy, in twenty lessons, the student, after a few lectures on diseases of the fundus, examines and is quizzed upon a hundred and fifty patients with pathological fundi—a most instructive course, which has its equal nowhere else in the world, save probably in Morefield Eye Hospital in London. In external diseases of the eye a dozen different cases are examined each day by each member of the class, after which he is closely quizzed upon the same. Little attention is paid to treatment; diagnosis and pathology being considered paramount. Other thorough courses are given on the bony structure of the orbit, anatomy of the eye, pathology, muscles, and operations on the cadaver and pigs' eyes.

In diseases of the ear, instruction is given on surgical diagnosis and treatment, anatomy and pathology, clinical work, operations on the cadaver, anatomy, physiology and pathology of the labyrinth, with special attention to the semicircular canals and nystagmus. The recent researches of Alexander and Barany upon nystagmus in connection with diseases of the labyrinth have aroused a great deal of interest in otological circles in Vienna, and the courses of each of these two scientific investigators are very popular with American students.

Diseases of the nose and throat are treated in the same thorough way, from anatomy up, and good operative courses on the living are offered. A very interesting course is that upon Bronchoscopy and Aesophagoscopy on the living, a branch which is receiving special attention from German and Austrian rhinologists at present.

In general medicine, good courses can be obtained in all branches, those in anatomy, pathology, bacteriology, internal medicine, pediatrics, skin, gynecology and obstetrics, being especially patronized by Americans.

Of the one hundred and ninety-five courses—many of which are duplicates by different professors—offered in the pamphlet published by the American Association of Vienna, eighty-four, or forty-three per cent., are upon diseases of the eye, ear, nose, and throat, and so great has been the demand for this work by Ameri-

cans recently, that in many of these courses the fees have been materially increased.

The fees for English courses in Vienna run from four to twenty dollars, with an average of about ten dollars for a course of twenty hours, in all branches except operative courses on the living, which cost from four to ten times as much as the others. If one understands German well he can obtain many University courses free, and others at a nominal cost of from fifty cents to four dollars.

In London, work covering a period of two or three months costs from fifteen to forty-five dollars, and at Moorefield Eye Hospital the fee for six months' work as Junior Assistant is fifty dollars, which covers every course offered by the institution, and further confers a life ticket of admission to the hospital clinics.

The student may count upon investing an average of fifty dollars a month for tuition in Berlin and Vienna, and about one-half that amount in London.

Besides London, Berlin, and Vienna, there are numerous other cities which offer facilities for post-graduate work, such as Edinburgh, and, in Germany, Heidelberg, Halle, Leipzig, Freidburg, etc., but in the latter cities a speaking knowledge of German is imperative. In Halle, very thorough and practical work on the ear can be gotten, including several mastoid operations on the living, for one hundred dollars.

The Physician contemplating a trip abroad for study, frequently asks which season of the year is best for his undertaking, and how long he must remain abroad to accomplish his work. To the former question the answer is that fall or late summer is generally the best time to set forth, because the fall and winter months are the busiest in European Hospitals, there are more Americans abroad then, ensuring the rapid filling of all courses, and the tide of transatlantic travel has by that time turned westward, causing low rates and abundant room for the Eastbound traveler. Work can be obtained throughout the summer months, but many of the chief surgeons are off duty at that time, and their clinics are conducted by first assistants. The Christmas holidays interfere but little with courses, the majority of them suspending from one to several days.

As to the length of the stay, this depends upon various considerations; the length of time which the busy physician can con-

cientiously spend away from home and practice, his inclinations, the condition of his pocket-book, etc.; but, generally speaking, he should allow two weeks for travelling each way, a week or ten days lost getting to work, and four weeks for each set of courses, if he goes to Germany or Austria. A somewhat shorter time for travelling should be allowed if he goes to London only, but from two to five months for study in the latter city, the instruction not being divided into so many and such short courses as on the continent.

The experienced man who merely wishes to brush up on a few subjects, or do general work, can accomplish a great deal in an absence of three months, one month of which is spent going and coming, and two at work, though he can find enough to keep him busy for an unlimited period. A six month's absence is much more desirable if it can possibly be managed, the practice at home will not suffer in the long run, and one can accumulate a marvelous amount of experience and knowledge in that length of time. Those who spend as much as two years abroad are to be envied, as well for their great store of experience, as for the thorough, careful and scientific methods which they are taught to pursue.

It is doubtful if the freshly graduated student of medicine should proceed immediately to Europe for post-graduate work. He does not realize how little he really knows, and it takes a few years in general practice, or a year or so in hospital work to show him wherein he is deficient, and along what lines he should apply his energy. Then let him go to Europe if he wishes, and he will get the maximum benefit of such a trip.

Living expenses are moderate, compared with corresponding expenses in our own large cities. The average price paid for board and room by the American student abroad is thirty-five dollars a month, though some pay less and some a good deal more. Cheaper board can always be obtained at a greater distance from the hospital district, but it is not advisable to take it on account of the valuable time consumed coming and going, and because one will not be thrown with American companions. In London nearly all Americans board along the several streets leading out of Russell Square, as this locality is situated in the center of the hospital district and Metropolitan London. In Vienna they frequent the side streets close to the "Allgemeine Kranken-

haus," and in Berlin they are scattered about the city on account of the widely separated hospitals.

The student can easily live upon forty-five dollars a month anywhere in England, Germany or Austria, which sum includes every expense except for traveling and for tuition. Travelling expenses from Georgia to Europe and return, via New York, will be from two hundred and twenty-five to three hundred dollars, according to route chosen, number of cities stopped in, etc. This includes every expense en route; tickets, sight-seeing, hotel bills, tips, cabs, etc., in eight or ten cities, first-class fare on all boats, and second class on railways. A doctor starting from some southern state can, during an absence of four months, get three months of post-graduate work in any European medical center, and pay all expenses, with five hundred dollars. For every month beyond four, a hundred dollars may be added.

A few practical points for the benefit of the inexperienced traveller abroad will not be out of place here. It is best to carry any sum, under a thousand dollars, in the form of American Express checks, as these are accepted everywhere without further identification than the signature, but larger sums should be invested in a letter of credit. For a stay of six months or less, do not carry a trunk, as only hand luggage is transported free on the continent, baggage rates are very high, and customs examinations are tedious and troublesome when there is a trunk to look up and open at every frontier; but rather carry two large suit cases as hand luggage, and turn them over to a porter whenever they must be moved, for which service the usual tip is the equivalent of five or ten cents, according to circumstances. Second class compartments are good enough for all save fools, nobles and millionaires, on continental railways, and even third-class is tolerable in England.

The sea route, shortest in distance, is from New York to Plymouth, and that shortest in time, from New York to Liverpool by the new monster turbiners of the Cunard Line. Berlin is best reached by boat from New York to Hamburg, and thence a short trip by rail, or via London and a twenty hour run by the Hook of Holland route. Vienna can be reached either across the continent a thirty-six hour journey from London, or thirty hours from the port of Cherbourg, France, through Paris and Switzerland, or through the Mediterranean to Naples or Genoa, across

Italy and Southwestern Austria. The trip through the Mediterranean to Naples, then through Rome, Florence, Venice, the beautiful Austrian Alps and Semmering Pass, to Vienna, is very beautiful and interesting, but to those who suffer the horrors of *mal de mer* it has a drawback in the twelve or fourteen day ocean passage.

The railways of Europe will sell the traveller cheap "rundreise" tickets, good for as long as ninety days, over any route selected by himself, no matter how devious, and allow stopovers in any cities along the way. Thus there are many interesting and instructive itineraries from which to choose, and by investing a little more money and a few days' time, many historical cities can be visited, even though superficially, and the mind of the disciple of Aesculapius broadened by this pardonable digression from the path of duty.

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After many years' work a modern medical library is almost ready for the use of physicians of Nashville and Davidson county. The library will have about 3,000 volumes and many medical journals will be kept on file. The library will be kept and cared for as a separate part of Carnegie Library. Should not the physicians of Atlanta carry forward her plan for a similar library?

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The following changes are announced in the University College of Medicine, Richmond: Professor of theoretical pediatrics, Dr. McGuire Newton; clinical pediatrics, Dr. Paulus A. Irving; theory and practice of medicine, Dr. Alexander G. Brown, Jr.; and practice of medicine and physical diagnosis, Dr. J. Garnett Nelson.

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The appointment of night inspectors in tenements to prevent the overcrowding of sleeping rooms is urged by representatives of the Federated Charities of Baltimore. Italian laborers are said to be the chief offenders, and one instance is reported where nearly a score occupied a room intended for two persons. The city authorities approve the suggestion.



## EDITORIALS

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We will present, postpaid, on request, to each contributor of an original article, twenty (20) marked copies of THE JOURNAL-RECORD OF MEDICINE containing such article.

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### OPENING OF THE MEDICAL COLLEGES.

Next week the College of Physicians and Surgeons, and the Atlanta School of Medicine will begin their fall term, and it is confidently predicted that there will be a large crowd of students in attendance at both of the colleges. The excellent equipment, modern in every respect, the corps of able professors and the abundant hospital facilities enable Atlanta to offer many and distinct advantages to medical students. Within the last few years both of these colleges have built large commodious quarters in which they are amply able to give thorough training in all of the medical branches. The high stand recently taken by the graduates of the Atlanta schools in passing the various state boards of medical examiners is unequivocal evidence of the excellence of the course of training. It is with pleasure we note the increase in the preliminary requirements, and we trust the standard may be raised still higher as the common schools of Georgia improve.

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### MUSQUITOES.

The \$2,000 appropriated by the city for the purpose of fighting mosquitoes has been exhausted and as a result Atlanta is

now having an epidemic of this disease-spreading pest. As long as the fund lasted and the campaign against the mosquitoes was waged, the city remained practically free from them. The health department has announced that its efforts along this line will now have to cease as the funds have given out entirely. Dr. Kenedy, city health officer, states that the fight should be continued six weeks longer, as September and October are two of the most important months for this kind of work. It is earnestly hoped that an appropriation will be made to continue this fight.

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#### DR. BOLAND'S SKETCH OF HENRY GRAY.

The biographical sketch of a great man in medicine is always a source of interest and instruction to the physician, and the September number of the American Journal of the Medical Sciences contains a valuable contribution of this nature, from the pen of Dr. Frank K. Boland, of Atlanta. The article is entitled "Henry Gray, Anatomist: An Appreciation," and shows the result of considerable investigation.

Although Gray's Anatomy is one of the best known of all medical books, information concerning the life of the author heretofore has been very scant. The reasons for this, as Dr. Boland explains, have been Gray's premature death and the fact that he left no direct descendents to record the particulars of his career. Apparently, this sketch exhausts all that can be learned of the brilliant young anatomist, after a lapse of a half century, and the profession is under obligations to Dr. Boland for his services as a biographer.

Henry Gray was born in London in 1827, and died of confluent small pox in 1861, at the age of thirty-four. He began the study of medicine at St. George's Hospital Medical School at the age of eighteen, and his student and professional course to success was uninterrupted. There is no truth in the story that he was a poor student and failed in some of his examinations. The facts, as obtained from competent authorities, tends to prove the very opposite. He was awarded several important prizes as a student, and became a member of the Royal Society at the remarkably early age of **twenty-five**.

The first edition of his "Anatomy, Descriptive and Surgical" appeared in 1858, when Gray was but thirty-one years of age. Although this work was his masterpiece, he wrote many noteworthy papers on other subjects. The Anatomy was a success from the first, notwithstanding the critics were by no means unanimous in their praise. Some charged the author with borrowing from Quin and Sharpey's work, which hitherto had been the most popular English text-book. These charges were not sustained, and it became well-established that Gray described only the dissections that were actually before his eyes.

The portrait of Gray accompanying the sketch, which was copied from a picture at St. George's Hospital, shows him to have been a strikingly handsome young man, with a high forehead and a powerful chin. There is but little recorded of the personal side of his character, and nothing said of his ability as a diagnostician or operator. The plan of his professional career, which is worthy of emulation, seems to have been first to ground himself thoroughly in the fundamental branches of anatomy and pathology, after which he would be equipped for the best possible work in the field of practical surgery.

Dr. Boland's summary, in these words, states very fairly the estimate in which Gray and his work are held today: "From this brief study of the life of Henry Gray, which was undertaken with the purpose of determining his true place in medical history, I am happy to conclude that he is entitled to the fame that is his. Although confessedly the glamor of renown has been augmented by clever illustrators, able editors, and progressive publishers, yet we could not fairly snatch away a single ray when we consider the part he played in the time allotted him. These factors are always instrumental in the success of such work. Gray's genius, like that of many others, consisted of hard work and singleness of purpose; could he have lived long enough to carry this with his spirit of investigation farther into medical science, it is reasonable to believe that he would have a name as great as surgeon as it is as anatomist and teacher."

It must not be supposed that no good work on anatomy existed before Gray made its appearance. The excellent books of English and French authors had strong following, and the new work was pitted against keen competition. But Gray felt that there was room for improvement in the old treatises, particularly

in the matter of arrangement and illustrations. He had a good conception of the principles of pedagogy, and desired, in so far as he could, to smooth for his students the hard road to anatomical knowledge. It was not the presentation of any new anatomical discoveries, but the clearer and more systematic presentation of old ones, backed strongly by unprecedented drawings, which secured for his book its phenomenal run.

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## NEWS AND NOTES

Dr. and Mrs. W. C. Jarnagin have been spending the summer at Norcross.

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Dr. J. L. Campbell and family recently enjoyed a very pleasant stay at Tallulah Falls.

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Dr. and Mrs. G. P. Huguley have returned from a very pleasant trip to North Carolina.

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Dr. J. Dawkins Cromer spent several days recently at Toxaway.

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Dr. A. W. Calhoun's many friends will be glad to learn that he has sufficiently recovered to be able to leave Johns Hopkins, where he has been ill for some time.

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Dr. A. L. Lawton spent several days in Atlanta recently. Dr. Lawton is now resident physician to Toxaway Hotel.

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Dr. and Mrs. Floyd W. McRae spent a portion of August in New York.

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Dr. Chas. R. Andrews enjoyed a very pleasant stay and delightful fishing in the mountains of North Georgia during the past month.

The many friends of Dr. E. C. Ripley will regret to learn that he has removed his residence to Meriwether county, where he will continue in the practice of medicine.

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The Seventh District Society of Physicians and Surgeons will convene at Cartersville, Ga., on October 14th. An interesting program is anticipated.

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In the death of Dr. H. B. McMaster, which occurred on the 21st, not only the medical profession, but the state at large, has suffered a severe loss. The community of Waynesboro, in particular, will miss the services of this devoted and conscientious worker.

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Dr. M. B. Hutchins spent several days in the mountains of North Carolina and reports a most enjoyable vacation.

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Dr. H. M. Smith, of Edgewood, Ga., left recently to visit his son, Dr. Leonard Smith, who is ill at Clayton, Ga.

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Dr. J. Edgar Paullin spent several weeks recently in and about Fort Gaines and Marshallville.

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In 1907 the mortality from plague in India reached the appalling total of 1,204,194. But a rapid decline has now occurred and the number of deaths in the twelve months ending June 30, 1908, is only 151,781.

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Mrs. Emanuel J. and William N. Senn have presented to the John Crerar Library, of Chicago, more than 2,000 volumes from the library of the late Dr. Nicholas Senn, to be added to the Senn collection.

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The names of 189 physicians have been stricken from the register of physicians by the Ontario Medical Council on account of non-payment of dues for three or more years. These men have declined, on principle, to pay the dues, holding that when they once become qualified physicians they should not be compelled to pay annual charges.

Dr. William Osler, Oxford University, has been made lord rector of Edinburg University.

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Dr. and Mrs. James B. Baird enjoyed quite an extensive trip through Canada, stopping at Atlantic City and other resorts on their way South.

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The annual meeting of the British Medical Association was held at Sheffield on July 27-31, and was attended by nearly 1,000 members.

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By the will of Frederick Hewett Owego, \$2,000,000 is bequeathed to the New York Post-Graduate School and Hospital.

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Dr. Roy Van Wart, of New Orleans, Assistant Neurologist of Tulane University, was recently in Atlanta visiting his mother at Howell Park Sanatorium.

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The Scottish local government report just issued shows that a very energetic campaign against consumption is being waged by the authorities of that country.

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Dr. Lewis M. Gaines, who is on the staff of the Journal-Record, announces elsewhere in this issue that he will give quizzes to aid those preparing to stand State Board and other medical examinations.

Dr. Gaines has had unusual advantages to equip him for this kind of work, having taught anatomy and physiology in one of the leading medical colleges of North Carolina for three years, and the coming session will give the course in materia medica at the Atlanta School of Medicine.

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For the first time in several years in this city the degree of Master of Pharmacy was conferred upon five distinguished men from different sections of the United States, who have attained distinction in the art of preparing medicines and drugs. Those who received this honor were Samuel W. Fairchild, of New York; Horatio Elson Fraser, of New York; John F. Hancock, of Baltimore; S. A. D. Sheppard, of Boston, and William McIntyre, of Philadelphia.—*Evening Bulletin, Philadelphia.*

At the annual meeting of the faculty of the Mississippi Medical College, Dr. William W. Hamilton was elected president; Dr. Nathan L. Clark, vice-president; Dr. Samuel H. Mairston, secretary; O. W. Bethea, treasurer; and Dr. T. Alexander Brown, dean.

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The Elkin-Goldsmith Sanatorium has recently issued the fifth biennial report of the surgical cases treated during the past two years in this well known institution. The report makes an excellent showing and demonstrates the high grade of surgery being done in Atlanta.

#### FULTON COUNTY MEDICAL SOCIETY.

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REGULAR MEETING, JULY 16, 1908, CARNEGIE LIBRARY, AT 8 P. M.

REPORTED BY R. R. DALY, M. D.

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None of the essayists for the evening being present, the session was given over to informal discussion of cases.

*Dr. Daly* described a case of petit mal in a boy of eleven. The seizures were frequent, 10 to 20 a day—but lasted only a few seconds. During these he sometimes fell and lost consciousness. He was photographed falling on a mattress. Another young boy was associated with him several weeks and then he, too, began to have seizures. These were judged to be imitative. The lad was soundly spanked for mimicing his associate and the simulated seizure ceased.

Children should be protected from associating with epileptics.

*Dr. Olmstead* reported a case of epilepsy with periods of amnesia lasting from 2 to 48 hours after the attack. The man would lose consciousness on the street and go home without remembering any of his movements. Sometimes he would fall in major convulsion and he has been taken to Grady Hospital at times. The medicolegal importance of such cases impressed the speaker forcibly. A crime might easily be committed during this epileptoid condition for which the patient would be entirely irresponsible. Indeed this has occurred and a case was cited showing the unfortunate complications.

*Dr. Sellman* reported a case of peculiar eruption occurring in a young woman. It appeared first as a macule, quickly becoming papular and surrounded by red circle. It rapidly became confluent and beginning on the arms covered nearly the entire body except the face. It increased in color to a bright red. It came on, as near as he could judge, from the symptoms of malaise at the fifth day and lasted about a week. After the rash had entirely disappeared there was general desquamation of the skin. The patient recovered uneventfully.

Several doctors were in consultation with him and the diagnosis was variously made as typhoid fever, typhus fever, measles, syphilis and scarletina. The typhoid condition was not marked, but there was fluctuating temperature and prostration. The increasing eruption suggested typhus, though it was not at all characteristic. Confluent measles was set aside because of no catarrh and scarlatina was thought of chiefly by the manner of peeling at the close of the fever. No one suffered any contagion, though many saw the case.

*Dr. Sellman* closed by saying he did not yet know what the disease was.

*Dr. Hutchins* said that it probably was a case of pityriasis maculata et circinata. In this disease there is an early desquamation, slight in amount, that might have been overlooked.

Again it might have been one of those unclassified eruptions due to any toxæmia from which the patient may have been suffering.

*Dr. Thrash* continued to believe it was typhoid fever. He saw the case and formed his opinion then.

*Dr. Olmstead* said typhoid was not to be mistaken in such a case. He agreed with *Dr. Hutchins* in the toxic origin.

*Dr. Thrash* related a case of small abscess in the neck of a young patient. It was opened, but did not get well and the patient returned to him on that account. Several biologic examinations were made by *Dr. Harris* and others without any definite result. Rabbits were inoculated with the secretion and seemed to thrive. After all sorts of things had been tried includ-



ing several serum injections, though tuberculin was not used on account of the good condition of the rabbits, the patient developed an acute milliary tuberculous of the lungs and died. No post-mortem was obtainable. Three and a half months after the first injection, the rabbits died of tuberculosis—too late to be of assistance in diagnosing the condition of the patient.

The slow, obscure progress of the disease was remarkable and confused all those who examined it.

*Dr. Armstrong* reported a case of ruptured appendix in which he did a drainage operation as a last chance and expected the patient to die. He placed him in the semi-sitting posture—the Fowler position—and a recovery followed. He felt the man was too weak for constant rectal enemata or he would have used that means also. The Fowler position not only increased drainage, but it kept the secretions in the pelvic part of the peritoneum which is less absorbent than the diaphragmatic.

*Dr. Hodgson* described a case of small tumor of the breast that had been growing at least four years. It was loose in all directions and he prepared for a simple enucleation under the breast. He found the capsule ruptured and the outspreading part showing enough of malignancy to call for a radical operation, which he then performed. Later examination showed progressive changes in the tumor even to the giant cells in the mushroom like process outside the capsule. The case gives additional warrant for the early operation upon all breast tumors.

*Dr. Stirling* reported a case showing difficulty in diagnosis in mastoid troubles. There had been recurrent furunculosis in the external meatus and periostitis as well, but these painful points had subsided under treatment. There was no discharge from the tympanum nor any evidence of trouble there.

After several weeks the patient returned with marked pain and tenderness over the mastoid and was operated upon. There was extensive disease all through the mastoid requiring general curretage, but the tympanum was not involved in any way. It is, these obscure cases doubtless that cause much of the meningitis the family doctor cannot account for.

PRESIDENT ROOSEVELT HAS ACCEPTED THE PRESIDENCY OF THE INTERNATIONAL CONGRESS ON TUBERCULOSIS. HIS LETTER TO DR. LAWRENCE F. FLICK, CHAIRMAN OF THE COMMITTEE OF ARRANGEMENTS FOR THE CONGRESS.

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THE WHITE HOUSE.

Washington, May 12, 1908.

Sir: It is with great pleasure that I accept the presidency of the "International Congress on Tuberculosis" which is to meet in this city on September 21, 1908, and extend its session to October 12, 1908. Official duties, however, may prevent my presiding at the initial meeting of the Congress, in which case I will deputize Secretary Cortelyou.

The importance of the crusade against tuberculosis, in the interest of which this Congress convenes, cannot be overestimated when it is realized that tuberculosis costs our country two hundred thousand lives a year, and the entire world a million lives a year, besides constituting a most serious handicap to material progress, prosperity and happiness, and geing an enormous expense to society, most often in this walks of life where the burden is least bearable.

Science has demonstrated that this disease can be stamped out, but the rapidity and completeness with which this can be accomplished depends upon the promptness with which the new doctrines about tuberculosis can be inculcated into the minds of the people and engrafted upon our customs, habits and laws. The presence in our midst of representatives of world wide workers in this magnificent cause gives an unusual opportunity for accelerating the educational part of the program.

The modern crusade against tuberculosis brings hope and bright prospects or recovery to hundreds and thousands of victims of the disease, who under old teachings were abandoned to despair. The work of this Congress will bring the results of the latest studies and investigations before the profession at large and place in the hands of our physicions all the newest and most approved methods of treating the disease—a knowledge which

will add many years of valuable life to our people and will thereby increase our public wealth and happiness.

The International Congress on Tuberculosis is in the interest of universal peace. By joining in such a warfare against a common foe the peoples of the world are brought closer together and made to better realize the brotherhood of man; for a united interest against a common foe fosters universal friendship. Our country which is honored this year as the host of other nations in this great gathering of leaders and experts and as the custodian of the magnificent exhibit which will be set up by the entire world, should manifest its appreciation by giving the Congress a setting worthy of the cause, of our guests, and of ourselves. We should endeavor to make it the greatest and most fruitful Congress which has yet been held, and I assure you of my interest and services to that end.

With expressions of appreciation for the compliment conferred in extending the invitation to become president of the Congress.

Very respectfully,

THEODORE ROOSEVELT.

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## BOOKS RECEIVED

THE PRINCIPLES OF PATHOLOGY. By J. George Adair, M. A., M. D., L. L. D., F. R. S. Professor of Pathology in McGill University, and Pathologist to the Royal Victoria Hospital, Montreal, Late Fellow of Jesus College, Cambridge, England. Volume I, General Pathology, with 322 Engravings and 16 Plates. Lea & Febiger, Philadelphia.

ANATOMY, DESCRIPTIVE AND SURGICAL. By Henry Gray, F. R. S., Fellow of the Royal College of Surgeons; Lecturer on Anatomy at St. George's Hospital Medical School, London, England. Seventh Edition, Thoroughly Revised and Re-Edited with Additions by John Chalmers DaCosta, M. D., and Edward A. Spitzka, M. D. Illustrated with 1149 Engravings. Lea & Febiger, Philadelphia.

**FOURTH ANNUAL REPORT** of the Henry Phipps Institute for the Study, Treatment and Prevention of Tuberculosis, Edited by Joseph Walsh, A. M., M. D., 238 Pine Street, Philadelphia.

**GOLDEN RULE OF DIETETICS.** By A. L. eBnedict, A. M., M. D., Buffalo. C. V. Moseby, Publishers, St. Louis, Mo.

**DISEASES OF THE SKIN.** Ready Reference Hand Book. By George Thomas Jackson, M. D., with 99 Illustrations and 4 Plates. Sixth Edition, Thoroughly Revised. Lea & Febiger, Philadelphia.

**BULLETIN OF THE BUREAU OF LABOR.** March, 1908. Government Printing Office, Washington, D. C.

**THE TRUE WAY OF LIFE.** By Nanny Randolph Ball Baughman, Burlington, Iowa. Published by the Author.

**INDUSTRIAL AND PERSONAL HYGIENE.** By George M. Kober, M. D., L. L. D. A Report of the Committee on Social Betterment of Homes. Published by The President's Home Cimmission, Washington, D. C.

**CONTRIBUTIONS TO THE SCIENCE OF MEDICINE AND SURGERY.** By the Faculty of the New York Post-Graduate Medical School and Hospital in the Celebration of the Twenty-fifth Anniversary, 1908.

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## BOOK REVIEWS

**THE NEWER REMEDIES.**—Including their Synonyms, Sources, Tests, Solubilities, Incompatibilities, Medical Properties and Doses as far as known, together with such Proprieties as have similar titles. A reference Manual for Physicians, Pharmacists and Students. By Virgil Coblentz, A. M., Ph. M., Ph. D., F. C. S., Professor of Chemistry in Columbia University, Department of Pharmacy. Fourth Edition Revised and Enlarged. The Apothecary Publishing Co., Boston, Mass.

This work presents an alphabetical list of the newer reme-

dies with essential facts concerning them and affords an easy and accurate method of referring to these preparations, many of which are not included in the works on *materia medica*, etc.

**REFERENCE AND DOSE BOOK.**—By. C. Henri Leonard. A. M., M. D., Emeritus Professor of Gynecology in the Detroit College of Medicine. New and enlarged edition; 40th thousand. Cloth, limp sides, round corners, thin paper, 16mo., 145 pages; price, 75 cents. The Illustrated Medical Journal Company, Publishers, Detroit, Mich.

The changes in the new edition of the U. S. Pharmacopoea are given in this edition of "Leonard's Dose Book" in two groupings, one showing those of "Increased Strength," the other of "Decreased Strength," and the new doses for these changes. All the Dose List has been carefully "proof-read" by several different readers, so as to insure absolute accuracy in the (nearly) 4,000 remedies given. The U. S. Dispensatory has been followed for medium and maximum dosage. The common name (in small type) is given after the drug name and dose. Besides this complete Dose List, the book has numerous useful Tables and a therapeutic index.

This new edition has been printed on thin paper so as to make it adaptable for buggy case or "bag," the whole being only one-fourth of an inch thick and weighing only about three ounces. Its round corners and smooth linen cover also make it "easy carrying" in the pocket. With this little book at hand you need never be at a loss for accurate dosage (new or old style) of a remedy.

**THE PRINCIPLES OF PATHOLOGY.**—Volume 1, General Pathology. By J. George Adami, M. A., M. D., LL. D., F. R. S., Professor of Pathology in McGill University, Montreal. Octavo, 948 pages, with 322 engravings and 16 plates. Cloth, \$6.00 net. Lea & Febiger, Publishers, Philadelphia and New York, 1908.

Professor Adami's new work is one of which the whole English-speaking world of medicine may well be proud. At a bound, it reclaims for the Anglo-Saxon a territory hitherto largely conceded to the activity of the Teuton. Translations or com-

pilations may be obtained, but the result is not to be compared with a first-hand native product in fitness for our needs. Dr. Adami stands fully on the level of his most eminent foreign confreres. He is broad and deep, but he possesses the saving quality of appreciating the fact that the easiest entrance for knowledge is by addressing the reader's faculty of reason. Having found this the best way to acquire knowledge himself, he so imparts it to others. His book is, accordingly, one that explains, connects facts in their natural relationship, rivets the attention and impresses the memory. In a clear and delightful style he displays the whole subject of General Pathology in this volume, to be followed by one on Systemic (including Special) Pathology. The phenomena of disease, or Pathology, are as definite and rationally connected as the phenomena of health, or Physiology. Obviously, the student and physician must have a thorough grasp of the underlying facts of disease, and must understand what it is in itself, before rational treatment is possible. Precisely this knowledge is available in its latest developments in Prof. Adami's pages, excellently set forth and amply embellished with illustrations.

**PREVALENT DISEASES OF THE EYE.**—By Samuel Theobald, M. D., Clinical Professor of Ophthalmology and Otology, Johns Hopkins University. Octavo of 551 pages, with 219 text-illustrations, and 10 colored plates. Philadelphia and London. W. B. Saunders Company, 1906. Cloth, \$4.50 net; Half Morocco, \$5.50 net.

With few exceptions all work on diseases of the eye, although written ostensibly for the general practitioner, are really adapted only for the specialist; but in Dr. Theobald's book *the requirements of the physician engaged in general practice have been made paramount*. For this reason only the common ocular maladies which the practitioner is constantly called upon to treat, the simpler operations which he is justified in performing, and the aids to diagnosis which can but prove helpful to him are described in detail and illustrated with many practical illustrations, mostly original. The difficulties with which he will have to contend in diagnosing ocular diseases have been made to aid him along this line. In the matter of treatment his needs are again particularly considered, the directions given being clear and concise, in every

case only one definite treatment being given. Just such a work has not heretofore been written, so that *Dr. Theobald's work is the one book written particularly for the physician engaged in general practice, and we commend it to our readers.*

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## MEDICAL ITEMS

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**PSEUDOANEMIA:** Do not forget that not every anemic-looking patient has anemia, a lack of red blood corpuscles. The diathetic state known as lithemia very often induces such a contraction of the peripheral circulation as to produce a condition of palor that may be mistaken for anemia. The condition, however, is one of ischemia instead of anemia, and does not call for iron. The therapeutic indications are to overcome the underlying lithemia, and for this purpose there is no remedy superior to Alkalithia, made by the Keasbey & Mattison Co., Ambler, Pa.

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Measured by every standard of purity, Peacock's Bromides is never successfully imitated. This is why it is necessary for the physician to see that the genuine is dispensed. He thus insures his results in all bromide treatment, particularly in this instances in which the prolonged use of the salts seems indicated and desirable. Neurologists have called especial attention to this featur of the preparation Peacock's Bromides, and therefore it is the severest therapeutic test to which the Bromides can be put, and there is no doubt that purity is of great importance in such cases.

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**CARDIAC TONIC.**—"I have prescribed Cactina Pillets in a number of cases of heart trouble and find them a reliable cardiac tonic, especially in weak heart with small, frequent intermittent pulse. They are a specific in functional heart trouble."—R. A. Clopton, M. D., Milan, Tenn.

# Journal-Record of Medicine

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VOL. X.

OCTOBER, 1908.

No. 7

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## QUACKS.

BY M. A. CLARK, M. D., MACON, GA.

"With monstrous promise they delude the mind,  
And thrive on all that tortures human kind."

It is impossible to ascertain with any degree of exactness when quacks first began to prey upon the sufferings of mankind. We find mention of them contemporaneous with Aesculapius, the god of medicine; and we have abundant evidence of their existence at the present day.

Words are hardly adequate to portray to you the wonderful progress made by man since the time of Aesculapius. Civilization has made marvelous strides. The whole world has been revolutionized by education; and every branch of science has kept pace with this advancement. When we consider what our profession was then and what it is now, we are amazed at the



progress made, and we marvel that there is still a place for the charlatan in medicine.

The eighteenth century has been called the "Quack Century." I apprehend that were the same author living in this the brilliant dawn of the twentieth century, he would not hesitate to predict that this century will out quack the "Quack Century."

Judging from the etymology of the word, the first quacks were those who talked extravagantly of the cures they had made and boasted of the usual skill they pretended to possess. You may easily find such as these thriving in this day and generation.

Then came the quacks who advertised their cures and made boast of their skill in the newspapers, and on cards and circulars printed in bold type and handed out to every passer by.

Steele in his *Spectator* of July, 1712, says: "Quack doctors, who publish their great abilities in little green billets, distributed to all who pass by, are to a man impostors and murderers." I doubt not but that the editors of our great newspapers of today would voice the same sentiment, and yet we find these journals full of advertisements of quacks and quack medicines.

We, too, have the advertising quack, and he differs but little from those of Steele's day, except that he is bolder and makes more frequent use of printers' ink, to delude the minds of the public. This is really the least dangerous of all quacks, because the methods are so bold and the motives so apparent that not a few recognize and avoid them.

During the life of Aesculapius there were those who stole his teachings and, under the guise of some queer name or party, preyed upon the ills of the credulous people. Hippocrates was beset by the same class of quacks. They have prospered throughout the succeeding ages and are today quite numerous though under new names. They steal what meager knowledge of medicine they have from the Regular Profession, yet spend much time and energy in encouraging the prejudices of the laity and ridiculing the real Science of Medicine. I am sure you all readily recall some under a new pathy, others under a so-called new religion, and not a few of us know how well they deceive the public, and how the public seem to revel in this deception.

They are multiplying at a rapid rate and are growing bolder and bolder in their practices. They set themselves up as experts more learned than the regular profession and even demand

that they be put on the same legal footing with us. Notwithstanding all this, they are not so dangerous to the people nor so injurious to our profession as another class of quacks, whom I now ask you to consider for a few moments.

There are certain little events in the childhood of all of us that are small indeed as compared with the realities of life and yet impress themselves more indelibly upon us than those of far greater importance. Are there any among us who will ever forget the first time we ever went to a circus or took a chew of tobacco? The very mention of these things carry us back to those happy days and we are living them over again or wishing that they could come again.

A few incidents of a medical character linger vividly around the memory of my childhood and seem as real as if it were but yesterday that they occurred. One, the veritable night mare of my childhood, is the old cup with a piece broken out and dark from the use of years, the bottle of castor oil, the old fashioned fire place with the little pile of hot ashes raked out to heat the cup that the oil might pour more readily, the cup of coffee to take afterwards to take the taste out," and last but by no means least, the peach tree switch so necessary to arouse my courage to the point of swallowing and nauseous dose. Can I ever forget that scene?

You may flavor, disguise, castor oil if you will,

But belch, and the taste will linger with you still.

With due apologies to the poet.

Another memorable epoch of childhood days is the event of the family physician when some of us were sick. Well do I remember how he sat by the cradle of my little sick brother and entertained himself with telling us of the many sick cases just like that only much worse, and how he was called just in time to save them from an awful death by his magic skill. How he came to see me once and found me "threatened with pneumonia" and was able to break it up and save me. Do you wonder that I would sit there agape, taking it all in and wondering how any one could know so much and be always so ready to do just the right thing at the proper time?

Have you ever heard of a medical man standing on the street corner or in the drug store talking in a loud and boastful manner to a crowd of acquaintances about the wonderful operations

he has performed; how the poor sufferer was cut all to pieces or his intestines were riddled with bullets and may be the liver had been penetrated, and yet with his great skill and dexterity the operation was quickly done, and the patient made a rapid and wonderful recovery; or of the number of cases of midwifery he has had, all difficult cases, and has never lost a case; or of the hundreds of cases of typhoid fever he has cured? He would love to talk longer with them but is so very busy that he must go.

How often has the poor patient been forced to lie there and listen to her doctor tell of so many cases that he has cured, all of them harrowing to her very soul and making her more nervous and restless. So full of self and so absolutely convinced of his own importance that he forgets the real motive for which he was called, and oft times his patient is worse than before he visited her.

Such is the quack within our own ranks, a graduate of a regular school of medicine, licensed as we are, and exercising all of the privileges belonging to us. He is a frequent boaster of his thorough familiarity with the Code of Ethics about which he really knows nothing, and is ever talking of his observance of Ethics and the absolute ignorance of it as shown by his contemporary. While this can hardly be termed a "brain storm," it is undoubted evidence of an exaggerated ego of a chronic character.

These men rarely have time to attend their medical societies and, too, never hear anything worth listening to if they do attend. Yet they spend much time in boasting of their skill and keeping themselves conspicuously before a gullible public. No real physician of the most perfect health and the greatest powers of endurance is able to do the amount of work and study they claim to do.

All of these men are not wholly worshipers of self and filthy lucre, but some fall into the habit because they have not the courage nor patience to wait to build up on that firm, but true foundation, Real Ability.

Hasten the day we shall be able to say that ours, the greatest and noblest of professions is wholly free from anything that even savors of quackery.

We must not forget to mention the class of quacks, who do not treat nor visit the sick, but who have discovered some panacea

for all diseases and spend their time and energies in advertising it to the public so fond of self medicating. Our minds are scarcely able to grasp the enormous amount of money spent each year for these remedies.

We may easily recall a remedy of this class advertised so insidiously that it deceived not only the laity but also many of the profession. Thousands of dollars have been made by them within a short period of time, and some of us have aided them so much in this by prescribing and recommending their preparation. I am sure you will readily call to mind many such remedies.

Now the all absorbing question, why do these quacks continue to live and thrive? The answer was given years ago: "Quackery and the love of being quacked are in human nature as weeds in the fields." It applies with equal force today.

Contemporaneous with the reason for quacks was given the remedy for the removal: "If all understood medicine, there would be none to take his quack medicine."

The laity have advanced in every branch of knowledge save that of Medicine. Only a short time ago, the editor of one of Georgia's best daily papers, in commenting upon doctors, said: "When it comes to doctors, one doctor is as good as another." If a man is called doctor, or peradventure is licensed to practice medicine, he is to the average person as good as the physician who has devoted years to study and research. Even the law recognizes him as much an expert as the most learned in the profession.

Then, Gentlemen, the real remedy for this great evil is to educate the people in such a way that they may be able and willing to discriminate. After they are thus educated, there will be no place nor demand for the quack, and our profession will be revered and prized as it so well deserves to be.

This education must come from the medical profession and must be wisely and carefully done. We spend much time and great energy and some money in learning a preventive for some dread disease and count all well spent. Can any prophylaxis be worth more to suffering humanity than that which will save them from the ravages of the quack. Like every undertaking by medical men for the good of mankind, this must be accomplished without any aid or much encouragement from the laity.

Our efforts at organization, Brethren, are but the right step

in this direction. The more thoroughly organized we become, the more easily can we arouse the profession to greater activity and the more rapidly educate the people to a full appreciation of the real value of our profession.

When this has been accomplished, the weeds of quackery will have been plucked from the mental fields of the people, and there will be none who will be willing to take the quack remedies, but all will look to the Science of Medicine for the relief from suffering and the cure of disease.

To make this organization complete and perpetual, we must rid ourselves of the petty jealousies so common among us and must cultivate with all diligence that greatest of virtues, Love.

"The night has a thousand eyes and the day but one,  
Yet the light of a bright world dies with the setting sun.  
The mind has a thousand eyes and the heart but one,  
But the joy of a whole life dies when love is done."

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### EXPLORATORY PUNCTURE OF THE DRUM MEMBRANE IN CERTAIN DISEASES OF THE MIDDLE EAR.\*

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BY DUNBAR ROY, M. D., ATLANTA, GA.

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To the medical student there is no literature so interesting as that which deals with the report of cases. As a teacher, I have frequently tried to solve the reason for this. If one will consider for a moment, he will readily discover wherein lies this peculiarity. I never read the report of a case in my own line of work but that it brings up another which has occurred in my own practice wherein similar or dissimilar characteristics are frequently seen.

I remember with what pleasure I used to peruse the pages of the old work of Toynbee's upon the ear and even now I read the same with pleasure and profit, all because he illustrates every subject with a number of cases which had occurred in his own practice.

To me such reports are exceedingly interesting and instruc-

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\*Read before the Fulton County Medical Society, September 17, 1908.

tive, so much that I am free to admit that the practical report of unusual cases carried more information with it than pages of theoretical suggestions. Such reports appeal to you as incidents which have actually occurred and which may occur at any time in your own practice. It is for this reason that I report tonight the histories of two cases and from them draw some deductions as bearing upon the title of this paper.

While some of you present may have had similar cases and may have had no difficulty in their diagnosis and treatment, the fact is true, however, that the various text-books on otology are silent upon such possible conditions being present during the course of a middle ear trouble and even other literature at my command is silent upon the subject.

Miss B., age 40, consulted me in June, 1899, on account of deafness, noises in the head, and intense pain around the ear.

From her mother I obtained the following history: Patient was never strong and robust. Was of a nervous temperament and two years ago was treated by a prominent neurologist for what he diagnosed as hysterical insanity. She had never been troubled with her ears up to five months ago when she was seized with severe pain in the left ear. She was treated by her home physician with particularly no result. On April 10, one month later she came to Atlanta and placed herself under the care of an otologist. He told her she was threatened with a mastoid abscess. The drum was punctured but she said she never felt or saw any discharge. She remained under treatment until June, and then returned home still suffering with pain. On June 26th she consulted me.

On examination I found a fairly vigorous looking woman of small stature. Wears glasses for hyperopia. Has a saddle back nose due to a perforated septum. She gives no history of syphilis, and the perforation was due to a traumatism. The mucous membrane of the nose looks healthy. Has some posterior hypertrophies of both inferior turbinates. Naso-pharynx shows nothing abnormal.

Right ear is normal in appearance and hearing power.

Left ear: Canal perfectly clear and no congestion present at any point. The drum appears thickened and opaque, but absolutely no redness. By inflation, the eustachian tube appeared

well open. No swelling or tenderness even on deep pressure over the mastoid.

Hearing: Watch, 6 inches. Whisper, one yard.

T. F. of middle register shows B. C. much prolonged over A. C. Same relationship, holds with forks of all registers. Complains of intense pain in front of ear and in the occipital region. A provisional diagnosis was made of otalgia and hysterical neuralgia. Patient was put upon increasing doses of iodide of potassium. Iodine was painted over the mastoid. The galvanic current was applied to the neck and occipital region. Menthol and iodine were passed per catheter into the middle ear.

At. 12:20 the same night of the first examination, I was called by the telephone to see the patient. She was complaining of the intense pain in the occipital region. This was relieved with an anodyne and the hot water bag. The next day the patient was as comfortable as on the day previous. The line of treatment commenced was continued with a varying degree of success until June 30th, when the pain continuing with such severity I decided to incise the drum membrane as an exploratory measure.

This was done under thorough antiseptic precautions, the incision being made posteriorly and well up into Shrapnell's membrane. This was followed by some blood and glairy mucus. The patient immediately experienced a feeling of relief. She was instructed to syringe the ear with hot carbolyzed solution every three hours.

The next day the patient still felt much relieved and the opening made continued patulous. Suction was made upon the drum with a Siegel's speculum during which there appeared at the incision a small red body like a polypus. This was seized with a pair of forceps and removed, it proving to be a mucous polypus about the size of a pea. From this time on the patient rapidly improved and in a few days the discharge ceased, the incision in the drum healed, all pain disappeared and the hearing power was equal to that in the other ear.

This case was reported in detail because its diagnosis was veiled in some obscurity. Since this observation and from further practical proof obtained in other cases, I am convinced that the majority of workers in otology reverence too sacredly the idea of puncturing the drum membrane. I do not believe that the puncturing of the drum membrane should be done rashly and at

random, but I do believe that if we are convinced of a middle ear trouble we should not hesitate to puncture the membrana tympani as an exploratory measure.

If this little operation is done under thorough antiseptic precautions, I believe that no harm ever results. These ideas are referable to cases both acute and chronic.

A great deal has been said and written about the puncture of the drum membrane in acute otitis media. Both sides have their advocates and after all such is but an expression of individual experience. He is a poor doctor who does not demonstrate for himself the usefulness of any remedy. Personally, I believe that I have been able to save my patients many hours of suffering and pain and many days of anxious watching and waiting by an early puncture of the drum membrane. I have never seen bad results follow when it was not used. I never hesitate to puncture a drum membrane if it is beefy red in toto and the patient is suffering with a throbbing deep seated pain. In such cases I have never failed to find secretion which, by its pressure presence was the cause of the pain.

Many a mastoid abscess has been aborted by an early and free incision in the membrana tympani.

In cases of subacute otitis media or where an acute case is long drawn out, where the congestion has disappeared from the drum and the ear still feels full and not relieved by inflations, in such case an exploratory puncture will do no harm and frequently prove of instantaneous relief to the patient.

Years ago Politzer called attention to the fact that frequently great relief followed the puncture of the drum where the same was greatly retracted, and there were marked symptoms of tinnitus and fullness in the head. In fact in his 1893 edition he devotes a chapter to this subject and lays down five indications for this procedure:

- 1.—In abnormal thickening and hardening of the drum.
- 2.—In immobilization of the malleus and incus on account of adhesive bands in the tympanic cavity.
- 3.—Where there are very intense and lasting noises in the ears which have not been relieved by previous ordinary treatment.
- 4.—Where there is a marked impermeable structure of the eustachian tube.



5.—As preliminary to intratympanic operations.

The incision of the drum membrane under the above conditions has frequently proven to be of great value to me.

I think otologists should try to eradicate from the minds of the laity the prevailing idea that the hearing is destroyed if the drum is punctured.

On the other hand I believe that such a puncture as a therapeutic measure is of much more value than is usually considered.

The second case is of mastoid involvement following an acute otitis media where all objective symptoms were practically absent.

On May 13, 1902, I was called by telephone to Macon, Ga., with instructions to come prepared to operate on a probable brain abscess.

I arrived about 8 p. m., and was driven to the home of Rev. J. L. W., the patient, where I met the home physicians in consultation.

From his attending otologist, a most excellent man, I ascertained the following history:

Four weeks ago the patient was visiting in Gainesville, Ga., and while there was attacked with severe pain in his right ear. He immediately returned to his home in Macon to consult an aurist.

His physician gave me the following history: Patient suffering with quite a little pain in the right ear, auditory canal was normal in appearance. The drum membrane was congested throughout, but absolutely no bulging. There was no rise in temperature. An acute otitis media was readily diagnosed.

Under the usual treatment all the unpleasant symptoms disappeared. His general health seemed much below par so his family physician took him in charge.

As he continued to have an occasional rise in temperature and some chilly sensations he was treated for malaria. The patient still complaining of some pain in the ear the aurist was again consulted. On examination he found a trace of pus in the auditory canal. This was wiped away and it seems to come from a little spot in the upper part of the canal. The drum was normal in appearance and there was no redness at any point. The patient still continued to suffer pain with occasional exacerbations of

fever and some chills. He was given as much as 5 grains of codeine daily to relieve his suffering. There was at no time any oedema or pain over the mastoid. In fact all pain was confined to the vertex of the skull and to the occipital region.

On arrival I found the patient fairly comfortable under the influence of codeine. Temperature was 101 F. Absolutely no pain could be elicited by pressure over the mastoid. The pain was confined more especially to the side and vertex of the head. The temperature in the morning had been almost normal. The auditory canal showed absolutely no abnormality and in contour it seemed just the same as on the other side. There were no signs of moisture. The drum also appeared perfectly normal and I looked in vain for even a trace of congestion. It had just the appearance of a drum in dry catarrh of the middle ear. As exploratory only, I incised freely the drum membrane. There was an escape of a small amount of blood and muco-pus. Believing that the mastoid was involved, I advised immediate operation. This being accepted, the patient was removed to the City Hospital, where with the assistance of Drs. Peete, Clark and Moore, the mastoid was opened. This bone was of a peculiar formation, very prominent and exceedingly convex on the outer surface. Considerable healthy bone had to be passed through before the antrum was reached. Only a drop of pus was found here, but on enlarging the opening several large cells were brought into view which were filled with pus. All of the mastoid was removed to the tip. A free communication was made with the middle ear. The bone over the sinus appeared healthy. The wound was then packed with iodoform gauze and dressings applied. A remarkable feature all during the operation, was the profuse muco-purulent discharge through the auditory canal. The patient was put to bed in a very good condition. The next morning at 7 a. m., I called to see him on my way to the train and found him free from fever and pain and expressing himself as being exceedingly comfortable. He made an uninterrupted recovery, and is now in better health than ever before.

This case presents some peculiarities. In the first place it illustrates the point which I attempted to make prominent in the report of the first case, and that is the value of an exploratory puncture of the drum membrane.

The history of this case shows that there was absolutely no

indication for puncture at any time during the course of the disease. I mean by indications such as are usually laid down by text books on otology.

The appearance of the drum membrane in this case was almost perfectly normal. The question also naturally arises, would not this case have recovered without an operation upon the mastoid had the membrana tympani been incised freely early in the course of the disease?

While an affirmative answer cannot be given with certainty, I believe that the chances for such a result would have been most excellent. I am even free to admit that there was a possible chance for such a termination at the time the puncture was made by me, since there was found to be such a free communication between the mastoid antrum and the middle ear, as indicated by the free discharge through the auditory canal after the puncture was made.

The second feature of this case was the total lack of all object symptoms of mastoid involvement. There was never any tenderness over the mastoid even under pressure; there were no signs of a sagging of the upper and posterior wall of the canal. The patient had many of the symptoms of malaria and it was very easy to see how a mistaken diagnosis could have been made. In these southern climates, where malaria is frequent, I have seen several cases where it was difficult to make a differential diagnosis. In country places one is not always able to have a blood analysis made.

Cases of this kind but teach us that stereotyped symptoms do not always occur and that we must be prepared for anomalous conditions at any time.

Every case reported, which has features distinctive from those usually seen, is of value to the profession as adding to the sum-total of our knowledge.

Grand Opera House.

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The Mississippi Valley Medical Association will be held at Louisville, Ky., October 13, 14 and 15, 1908, and judging from the preliminary program, this meeting will be of much interest to all physicians who are able to attend.

## THE TREATMENT OF THE MORPHINE HABIT IN GENERAL PRACTICE.\*

MORPHINOMANIA—THE MORBID DESIRE FOR MORPHINE—THE  
OPIUM HABIT.

BY GEO. H. LEHMANN, AUGUSTA, GA.

Before taking up this subject, I wish to make it plain to you gentlemen that I consider the confinement in some well regulated institution of all morphine fiends absolutely essential, and where the patient can stand the expense, this should always be done. But, unfortunately, we find a great many of these poor creatures who are unable to bear the expense of an institution with its skilled physicians and attendants. To this class the physician is called upon from time to time to treat. Now, the average practitioner has very little sympathy for this class of unfortunates, for experience has taught him that no reliance can be placed in this class of patients, while the treatment instituted is positively worthless or unsatisfactory. The morphine habit is often acquired by patients for whom the drug has been prescribed by a physician to control obstinate pain or sleeplessness, or from self-administration, or certain patent medicines. It is more frequent in women than in men. Physicians are often addicted to this pernicious habit, in fact, more so than any other professional body. Morphine is taken either by the mouth or hypodermatically, and while some few subjects continue to take the same small quantity of the drug, the tendency is to gradually increase the dose until 40 grains or more are employed.

In the East, opium eating and smoking are very common, yet the Orientals seem to stand it without any marked bad effect. The continued use of small doses of morphine may for a long time result in no marked manifestations other than a craving for the drug, but sooner or later the functions of both body and mind become affected. While under the influence of the morphine the patient may feel well, but as the effects disappear, mental disquietude, depression, nausea and abdominal pains follow, which can only be relieved by further recourse to the drug. The character of the morphinomaniac becomes deteriorated and

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\*Read before the Richmond County Medical Society, Augusta, Ga., July 14, 1908.

is typified by lack of self control and of moral sense—the patient loses all sense of right and wrong. He will lie and steal in the most degrading way, especially if his desire is to obtain the drug, and absolutely no statement that he makes can be trusted. He neglects his work and lets his business go to ruin. He becomes anaemic, suffers from loss of appetite, indigestion, dry mouth, sluggish bowels, and a foul tongue. The nails are brittle, the skin is dry, the hair turns gray early and falls out. There is sexual impotence in the male, no erections take place, no semen is secreted. In the female there is amenorrhea, and the flow of milk is stopped, but there is polyuria. The pupils are small, there is loss of muscular power, slight ataxia and tremor in severe cases. The arms, legs, and in fact, every portion of the body that can be reached, are scarred by marks of the needle. Certain subjects live to moderate old age, and even, though the habit continues, are able to transact the usual duties of life. These, however, are the rare individuals who get along on a small and not increased quantity of the drug.

A common feature of all narcotic inebriety is the frequent perversion of the affections. Love is transformed into hatred, and the narcomaniac not unseldom loathes the sight of the devoted companion whom, in his prenarcotic years, he cherished with the tenderest affection. Opium transforms the manly, high-toned, pleasant companion into an effeminate, driveling, querulous bore. In some localities, especially in China, the opium degradation is so terrible that gross immorality abounds. So intense is the crave that a man has been known to mortgage his mother and sell his wife to gratify it. One man sold his wife for 12 pounds and smoked the proceeds. The crave robs a man of his resources, unfits him for work, and hurries him to an untimely end. J. L. Maxwell, in the *Lancet* of January 2nd, 1893, says that one hundred thousand persons commit suicide by opium every year in China. In Hardai, of 180 suicides in three years, 97 were from opium, and 80 per cent of these being females. Morphine produces abulic states which predispose to impulsive conceptions, leading to theft usually of senseless nature.

**DIAGNOSIS.**—Opiomaniacs and Morphinomaniacs are often difficult of detection, especially is this true if they have a supply of the drug about them. Norman Kerr says: In one case a brilliant young medicine student had habitually taken opium for

two years without the habit having been suspected by the chum who shared his room. The truth was disclosed unexpectedly, owing to an unusually large dose having been taken by mistake. It is astonishing how dextrous with the hypodermic syringe the inebriate becomes. The diagnosis of morphinism is easy. On examining the arms, scars caused by the use of the hypodermic syringe, are readily seen. To find morphine in the urine, take twenty ounces of the suspected urine, and if not acid in reaction, make it so by adding diluted hydrochloric acid and concentrate to about three ounces, when it is allowed to stand in a cool place for twelve hours; then filtered. To the filtrate is added sufficient sodium carbonate to make it alkaline. It is then allowed to stand twelve hours, filtered, and the precipitate collected and washed with distilled water made slightly alkaline with sodium carbonate and dried. The dried precipitate is digested with pure alcohol at a gentle heat and filtered. This is evaporated to dryness. The residue is dissolved with diluted sulphuric acid and tested for morphine by iodic acid test. Iodic acid is reduced by morphine rendering color of solution brownish from free iodine, changing to bluish black on addition of starch water.

ETIOLOGY.—The Medical Record in an editorial of June, 1897, says that of male morphinist, the medical profession supplies the largest number—40 per cent. Men of leisure comes next with 15 per cent. Then merchants with 8 per cent., while clergymen, peasants and politicians occupy the lowest position on the list. Women of means are the most numerous class among the females, 43 per cent., followed by the wives of medical men with 10 per cent. A sedative for the relief of pain has been the origin with many. Neuralgic pains being generally relieved as if by magic when introduced subcutaneously. J. B. Mattison, in the Medical Record of January, 1895, says that neuralgia is the most prolific cause of morphinism. Injudicious medical prescriptions has had much to answer for in introducing the practice of the auto-injection of narcotics.

PATHOLOGY.—The pathological changes observed in morphinism are few and limited. The shrunken and withered appearance of the habitual inebriate is a fair representation of his internal condition. Erlenmeyer, in the American Journal of Medicine of April, 1904, says that morphine in the body, by taking up oxygen, is changed into oxidimorphine, which later gives rise to

symptoms of abstinence. Organic lesions are comparatively rare. Opium may be a contributory cause of paralysis, but it does not act directly as a paralyzer.

**TREATMENT.**—In hospital practice, opium or any of its derivatives, may be withdrawn suddenly, and hyoscine hydrobromate substituted, but this method, in my opinion, is positively cruel, causing untold suffering on the part of the patient from three to four days. J. C. Verco, in the *Australian Medical Gazette* of March 20, 1899, says that the following method of treating chronic morphinism is simple, safe and satisfactory. A mixture containing five grains of bromide of soda to a drachm is ordered, and a drachm of the mixture is given every three hours; the dose is increased by a drachm every day. By the time the patient is taking 1-2 drachm doses of the bromide every three hours for a day or two, he will probably be able to do without his morphine. If the drowsiness by this time is profound, the bromide may be withdrawn; if not very deep the bromide may be gradually withdrawn. On May 22, 1901, C. B. A. Barber came to my office and informed me that he wished to place his case in my hands for treatment. This man was a confirmed morphine fiend. Some twelve or thirteen years before he stated that he suffered from rheumatism, and his physician gave him morphine hypodermatically, sometimes as often as three or four times daily for relief. The physician finally realized that he was about to make a fiend of his patient and ceased the administration of the drug. He saw nothing of the man for several days, and when he did, inquired why he had not called at his office for further treatment. He stated to the physician that when we refused to give him the morphine, he immediately went to a near-by drug store and bought a hypodermic syringe and morphine and began treating himself. He kept this treatment up persistently for about thirteen years, when he came to me for treatment. At the time he was taking one drachm of the powdered drug daily. His arms, legs and body were a mass of scars—I never before saw a more pitiful specimen of humanity. He was anxious to be cured of the habit, and I told him I would take his case if he would pledge me his hearty co-operation in the treatment. This he readily consented to do. I relieved him of his syringe and told him that whenever he felt that he must have the drug, come to my office and I would administer the necessary quantity. For the first

three days I gave him six grs. four times daily, and at the end of the week I had reduced the quantity to fifteen grs. given in three doses. Keith's Concentrated Tincture Avena Sativa was given from the first in increasing doses, beginning with ten gtt. Saturated solution sodium iodide was given before meals in milk in increasing doses, for the purpose of bringing about a rapid elimination of the drug. Strych. sulph. was given with the morphine hypodermatically beginning with 1-60 grs. and gradually increased as the morphine was decreased. At the end of five weeks I had completely withdrawn the drug and my patient had gained about ten pounds. He was dismissed with a prescription for strychnia granules grs. 1-40, to be taken every four hours.

This man lived in Augusta for nearly three years afterwards and during that time there was no relapse, subsequently I was informed that he became addicted to strong drink, and finally lost his position and left Augusta, and of course, passed from observation.

Case No. 2.—Mrs. W., a distant relative, residing in western Georgia, had been addicted to the drug for five years. Her physician gave it to her for the relief of neuralgia from which she was a chronic sufferer. She purchased a syringe and afterwards administered the drug herself. Her husband placed her in the Woolleys Institute of Atlanta, and the drug was suddenly withdrawn and hyoscine hydrobromate substituted in large doses. She remained in a semi-conscious state for about seventy-two hours. After recovering from the effects of the hyoscine, she passed into a state of nervous collapse, which so frightened the physicians that they immediately summoned her husband to Atlanta. Three days later she left the institute, saying she could not take the treatment. Three months afterwards she came to Augusta and remained at my house during the course of treatment. She was taking about six grs. daily hypodermatically. The treatment given was the same as given in the first case. In three weeks the drug was completely withdrawn and she had gained six pounds. I saw this patient about two months ago. She had gained about thirty-five pounds since I dismissed her four years ago. She stated that during that time she had several severe attacks of neuralgia, but would never permit her physician



to give her morphine—she had a perfect horror of the drug, and under no condition would she take it again.

Case No. 3.—L. A.—A denizen, of the Red Light District, in 1904 applied to me for treatment. I refused to take her case unless she would consent to go to the hospital, which she did. At the time she was taking about 10 grs. of the drug daily, hypodermically. On reaching the hospital she was placed in bed, where she remained for two weeks when the drug was completely withdrawn. In this case nothing was used except the solution of iodide and the *avena sativa*, plenty of nourishment, rich milk and broths. She was discharged at the end of three weeks. In this case there was a relapse, which was due to her physician giving her morphine to control the pain of facial erysipelas. That a relapse would come about sooner or later in this patient was to be expected, as her very life, surroundings and environments were all predisposing factors. I have a record of some twenty-two or three cases, and the cases just mentioned were taken from my records just as they came in one, two, three order. I believe that 80 per cent. of the morphine fiends can be cured., 40 per cent. of these will relapse from time to time, while fully 40 per cent. remain permanently cured.

RECAPITULATION.—Much may be done by the physician in the way of prevention of the morphine habit. The indiscriminate prescribing of the drug can not be too strongly condemned, and it is a positive crime to put a hypodermic syringe into the hands of a patient to be used in the control of pain or sleeplessness. Be frank with your patient—make it plain that you can and will cure him with his co-operation, when possible, place him in bed for a few days, and by all means insist on his remaining in doors during the course of treatment. Begin with 15 gtts. of Keith's concentrated tincture *avena sativa* four times daily in hot water, gradually increasing the dose until thirty or forty gtts. are given. A fullness at the base of the brain will indicate that the dose must not be increased, and a pain in that region suggests that an overdose has been given. *Avena sativa* is a *nerve stimulant, tonic, laxative, solvent* and *diuretic*. The morphine is gradually reduced, while strychnine sulph. given with the morphine, is gradually increased, and, as a rule, the drug can be completely with-

drawn in from ten to fourteen days. Sat. solution sodium iodide is given in increasing doses before meals in milk, beginning with ten gtts. This brings about the rapid elimination of the drug. In some cases trional in fifteen grs. doses at bed time will have to be given. In women of highly nervous temperament, I have found that John B. Daniels concentrated tincture of *passiflora incarnata* has a wonderful sedative effect upon the nervous system. So effective is this drug that I rely upon it entirely now, whereas before I used the bromides. Hardly any two cases can be treated exactly alike, therefore the medical profession should alter the treatment in such cases where the above is not applicable, using their judgment, though following along the same general lines.

In conclusion, I will say be patient, be merciful to these poor unfortunates, for they are not entirely to blame for their wretched condition.

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## CONSERVATISM IN RAILWAY SURGERY.

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BY W. P. WHITTINGTON, M. D., ASHEVILLE, N. C.

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In presenting this paper, I do not wish to do so in a spirit of criticism, but wish to say something that will be of benefit to the Surgeon both civil and railway, and that will possibly be the means of saving the life or a useful limb of some unfortunate victim of a railway accident.

The position of a railway surgeon is a dual one; professional and diplomatical. His professional duty would require him to consider specifically the relief and safety of his patient, while as a railway official he must take into consideration the interests of the company by which he is employed. In reality he should and must have at heart the mutual interest of both. While this is very desirable it is still a hard matter to eliminate the influence of the employer over the employed and do justice both to the

railway and the injured. The powers and influence of the surgeon over public opinion, is such that he may easily favor his employer, and at the same time make it appear that he has done the best possible for the injured.

For instance, the surgeon may be called to a patient with a mangled hand or foot, that looks to the layman to be beyond repair, or out of the power of the surgeon to save. The surgeon knows that if the limb could be saved it would require a long, tedious watching, and careful antiseptic treatment. He also knows that if he amputates above the injury he has healthy tissue, a clean stump and that in two or three weeks the patient is well, but minus a member that might have been saved and have been of great benefit to the injured.

In such a case the surgeon is commended for doing the best thing possible for his patient. The patient is furnished an artificial leg, or given a small compensation for a hand and goes through life maimed and worth but little to himself and family; when if he had been treated antiseptically this limb would have been saved and would have been a great blessing to himself and family.

I know a man who had a badly lacerated hand and his surgeon told him it must be amputated. The patient refused to have it done. The surgeon told him that he would have to put him to sleep before he could dress it. The patient submitted to the anaesthesia, but told the surgeon that if he amputated the hand he would kill him. The hand got well and the man can do any kind of work. He has a crippled but useful hand.

I know a man who had a compound comminuted fracture of the leg, opening up the ankle joint. It looked like an impossibility to save the foot. The foot was wrenched to one side so that the ankle was dislocated and the end of the tibia protruded through the skin. A drainage tube was passed clear through the joint, and the leg was treated antiseptically. The man got well with a useful foot and leg, but with a limited amount of motion. I could report a great many cases of extensive laceration, fractures, contusions and mangled conditions that have been saved by patient and persevering antiseptic and supportive treatment. While on the other hand I have seen valuable limbs sac-

rificer for want of such treatment. One might say that it is best not to subject our patients to so great a risk as is necessary to carry out an expectant antiseptic course of treatment. That there is danger of sepsis, gangrene and death. That there is always some danger we will admit. The surgeon should be very alert and when bad symptoms appear he should pursue such methods as is necessary to remedy the threatened evil. We are not justified in amputating a foot because a nail has pricked the heel and we are afraid the patient might have tetanus.

The method to pursue in these cases of railway and other injuries to the extremities is one of thorough antisepsis from the beginning. The patient should be cleansed as thoroughly as possible without further contaminating the wound. The injured limb should then be thoroughly washed with soap and water, bichloride of mercury one in two to four thousand, owing to the extent of the injury. This should be followed with alcohol and ether and finally rinsed with bichloride. In extensive injuries where there is a great deal of denuded tissue, it is best to continue a wet dressing of a saturated solution of boracic acid or sulphate of alum. In very extensively mangled legs or arms the limb may be immersed for from twenty-four to seventy-two hours in a saturated solution of sulphate of alum. This solution of sulphate of alum is not extensively used, so far as I am informed, but it is practically harmless and has fine antiseptic powers and acts as an astringent on the extensively lacerated and bleeding tissues. As soon as the bleeding ceases and if the tissues show an anaemic appearance the solution should be discontinued or made weaker. Dry or moist antiseptic dressing should be continued and sloughing surfaces separated as early as possible, care being taken not to open up raw surfaces more than is necessary, as such a proceeding would encourage the absorption of septic matter. Another good method is after the parts are thoroughly cleansed with soap and water, to mop the raw surface thoroughly with pure carbolic acid followed with 95 per cent alcohol, and paint it thoroughly with tincture of iodine. After healing has taken place it may be necessary to do plastic operations to complete the work that nature failed to do.

## EMPYEMA : ETIOLOGY, SYMPTOMS, TREATMENT AND WHEN TO PERFORM THORACOTOMY, REPORT OF CASES.\*

BY JOHN T. BURRUS, M. D., HIGH POINT, N. C.

In looking over the records of papers and reports of cases before the North Carolina Medical Society, I am unable to find a report of Empyema or any article on the subject, and since I have had a number of cases, I have taken this subject for my text. Therefore I invite your attention to this subject for a short while.

The term Empyema, denotes the presence of pus in the pleural cavity, (or pleural abscess). We have two classes of cases, that of Empyema in childhood and in adults. In childhood it is very plain and the symptoms enable us to make a very early diagnosis.

In the adult the diagnosis is very much more difficult to make, and usually requires a longer time than it does in childhood.

*Etiology.*—The causes of Empyema are due to the presence of pyogenic-bacteria in the pleural cavity, and is almost always secondary to some other disease.

1. Secondary to Sero-Fibrinous effusions where Thoracentesis has been performed for Sero-Fibrinous effusion and antiseptic measures have not been strictly adhered to, and secondary to pneumonia, scarlatina, pyemia, tuberculosis, dysentery and some times measles, whooping cough, carious ribs, carious vertebra and trauma.

2. Lymphatic metastasis is a probable way in which bacteria reaches the pleura, from neighboring tissues. The organisms which in most every instance has been found to produce this condition is the micrococcus lanceolatus, streptococcus, staphylococcus and tubercle bacillus.

*Symptoms.*—The history of the patient is important and my experience with the disease shows that 90 per cent of all cases occur after pneumonia or plurisy.

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\*Read before the North Carolina Medical Society, at Winston Salem.

Where the case runs an ordinary course of pneumonia or pleurisy and perhaps the patient begins to improve, fever reducing and at the time apparently begins to convalesce. For a few days the patient has every indication of doing well, when a chill comes on followed by fever and pain in side. The symptoms are at first looked upon as a relapse. In a few days dyspnoea, restlessness and immobility of the affected side.

In childhood the symptoms are more rapid in developing than in the adult. In a few weeks the clinical picture is changed. The patient that was once plethoric now becomes very much emaciated. The short loose cough suggesting a tubercular condition, which is in many cases confirmed when the night sweats appear. The general appearance of the patient is that of extreme exhaustion.

Physical signs are: Pains in the affected side, dyspnoea and evidence of absorption of pus, skin cold and clammy and oftentimes bathed in perspiration. Respiration is from 36 to 50 to the minute. Temperature varying from 101 F. to 105 F.

There is a dullness in the affected side with change of sound according to the position of the patient. A disappearance of vocal fremitus on the affected side.

The bronchial murmur may be perceptible if the accumulation is not too extensive, but if the effusion is sufficient to occupy most of the pleural space, then bronchial murmur is not heard.

In childhood the bulging of the affected side is not so marked as in the adult, owing to the thoracic viscera being less resistive and more easily displaced as in childhood.

On measuring the side from the center of sternum to the spinous processes, the affected side is seen to be larger, varying according to the amount of pus in the cavity.

In some cases we have the rupture into the bronchi of pus, which is expectorated, and occasionally this relieves the patient, and recovery is the result.

*Treatment.*—In cases of empyema I have very little faith in leaches, blisters, poultices or the other external appliances which have been suggested; neither do I believe in waiting for these cases to rupture or to go so long that the bulging is so extensive that it is ready to rupture externally. But as soon as

a diagnosis can be made I think that every case should be operated on.

Usually we allay pain, that our patient may be more comfortable; give a mercurial purge, supporting the heart by giving heart stimulants, and diffusible stimulants such as ammonia, strychnine, antrophine, and digitaline. But the only thing that I have done in these cases, that gave me any results was thoracotomy as early as I could make the diagnosis. And the positive diagnosis is made by the introduction of a trocar obtaining pus.

The positive diagnosis made, I next proceed to do thoracotomy. This should be done by making an incision two and one-half inches long in the six or seven interspace in the mid-axillary line. First observing the strictest antiseptic measures.

If the space is large enough to admit a large size rubber tube, then it is sufficient, but if not, you should resect a rib, which is done in the usual way. This gives a space sufficient to allow free drainage. The tube should be held in situation by ligatures. To the drainage tube there should be a long tube connected, which conveys the fluid from the drain to a vessel containing an antiseptic solution. This acts for two purposes; first, preventing the induction of air, dust or any infection into the pleural cavity, and secondly prevents the dressings from becoming soiled by the drainage, thereby making it more comfortable for the patient.

The after care of the patient demands a consideration. First, stimulate and nourish, second, to see that the tube does not become obstructed, thereby facilitating the free escape of the fluid.

So long as the flow is free, I never irrigate the cavity, but if the flow is very tenacious and does not flow freely, then a weak solution of permanganate of potash, or a normal salt solution is used to irrigate the cavity.

Strych-nitrate syr-hyphophos and nourishment are always instituted and the patient urged to take plenty of fresh air.

Thoracotomies, case No. 1.—Mollie J., age 11 years, white, history good, no scrofula, syphilis or tuberculosis in family. Was taken ill December 15, 1907, with chill. Fever 105 F., 130, high arterial tension, a rapid respiration, and severe pain in left side, complaining of aching all over body. I examined the patient on

evening of same date and found her with pneumonia of left lung.

The case run a rather severe course to the 8th day, when fever terminated by crises, and patient began to improve.

On the 14th day I dismissed the case, as the patient was now sitting up and very desirous of food, the cough having almost subsided by this time.

Six days later I was called in and found that 3 days after I dismissed the case she had developed a chill, rapid respiration and a good deal of fever, having a severe cough and not able to expectorate anything. Dyspnoea marked and an inability to lay off of the affected side.

I found upon examination that there was obliteration of inter-costal spaces and heart was displaced to right as far as the median line with dullness over the entire left side.

I introduced an exploring needle into the thoracic cavity and obtained nothing. Whereupon I did not advise an operation.

Four days later I made another exploratory puncture and obtained a small amount of pus. I advised an immediate operation and on the following day Dr. Duncan and myself did a thoracotomy, going through the sixth interspace, between the mid and post axillary line. We introduced a drain and while at first the discharge was very slight, owing to the tenacious pus, but by the third day the patient was discharging large quantities of pus through the tube.

The tube remained in situ for three weeks and was removed. The patient is well and in a fine physical condition, suffering no discomforts from the side, and has made a speedy and uneventful recovery.

Case No. 2.—A. AL. s. child, female, age 7 years. Family history good. Father and no mother living, two brothers and one sister, none dead. Child has never been sick, except measles at the age of two years, from which she had recovered.

January 25, patient was taken ill with pneumonia, which was treated by another physician. On April 1st, Dr. Dorsett was called and diagnosed empyema and urged an immediate operation. The family objected to this and on the 14th, I saw the case with Dr. Dorsett and obtained the following history.



On January 25, 1908, child was taken ill with pneumonia in left side and was very sick for two weeks, then she began to improve, and at the end of the third week sat up in bed and called for something to eat.

At this time she had no elevation of temperature and was getting better. At the end of the fourth week patient had a chill and a slight rise of temperature, pain in side and difficult breathing, a dry cough that worried her a great deal, but was unable to expectorate anything.

The case went on in this way till the end of the 8th week. Child spat up quite a quantity of what the parents said looked like pus. Then she improved for a week, but from that time she began to grow worse up to the time I saw her, April 14, saw case and found extreme emaciation, temperature 101 F, pulse 140, respiration 46. Skin cold and clammy and bathed in perspiration. A very anxious expression on her face and every few minutes she would have a paroxysm of a very severe cough and was unable to expectorate.

Physical examination revealed the following. Heart displaces two and one-half inches to right of sternum and upwards, obliteration of intercostal spaces on left side and oedematous.

The measurements revealed the left side two inches larger than right. The abdomen was distended and the child was nothing but a bony frame covered integument.

On April 15th, Dr. Dorsett and myself did a thoracotomy, using very rigid antiseptic precautions, making an incision two inches long in the seventh interspace in the mid-axillary line.

A large rubber tube was introduced and anchored by ligatures. We removed five pints of liquid pus. The child's abdomen reduced and the heart became less frequent.

The tube remained in situ three weeks and drained freely all the time. Then we changed the drainage tubes, using a smaller one, and irrigated with a weak solution of hydrogen di-oxide. The tube remained in situ for three weeks longer, making six in all. When there was no further drainage it was removed.

After the operation the child was put on Syr. of Hydriodic acid nutritious diet and the open air.

This case made a good recovery and has gained a **great** deal of flesh. I report the two cases to show the difference where earlier operation is instituted and where the case has been allowed to remain so long without surgical intervention.

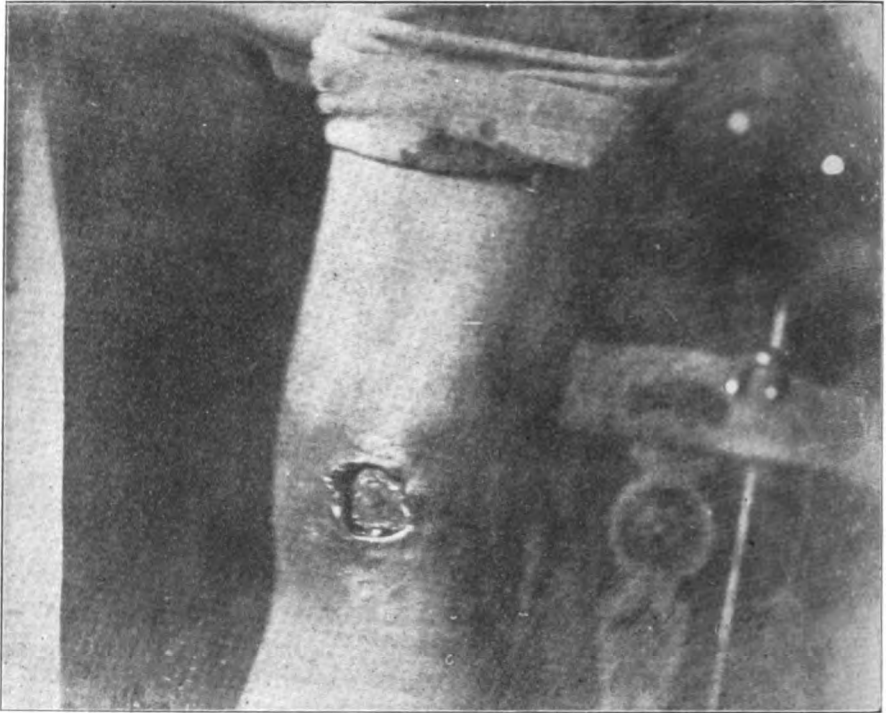
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## REPORT OF A CASE OF TROPICAL ULCER.

BY DR. W. E. WILMERDING, ATLANTA, GA.

Mr. W., aet. 32; father living, aet. 58 in good health; mother died at 40 of pulmonary tuberculosis, as did both of her parents. Always had good health until December, 1905, when a wound made by a sharpened bamboo just above right ankle, while in the Philippine Islands, serving as a private in the U. S. Army, became infected and later developed into a tropical ulcer. This ulcer lasted until August, 1906, when it healed and he returned to duty. In November, 1906, he noticed a small swelling, hard and brawny and about the size of a pecan, in the right popliteal space; this gradually increased in size until January, 1908, when it was about three inches in diameter, nearly round, very hard and of a dark red color. Late in January he noted a fissure across the center which presented the appearance of an incised wound. At this time he came under my observation, and in a few days this fissure had enlarged to the size of a silver dollar, was nearly round, had overlapping edges, and had for a floor a dirty grey tenacious slough. There was no pain at any time and no interference with locomotion. A specific history was denied, and there was no evidence of any specific lesion elsewhere on the body. Under the use of pure carbolic acid applied every other day to this slough and packing the ulcer with iodoform gauze, and a thorough irrigation with a 1 to 500 permanganate solution, this slough disappeared and the ulcer presented a clean cut border and an uneven floor and a depth of about 1 1-2 inches. Granulation gradually filled up this cavity and after several months only a slight scar was left. The case was dismissed May 11th, 1908 as cured, but the patient returned in a few weeks with a small hard nodule in the calf of the same leg, which

presented every indication of being the beginning of another tropical ulcer. Incision and complete removal of the mass was urged, but refused, and after a few weeks this mass showed a softened area which when opened liberated a small amount of thin pus and disclosed a dirty grey slough which extended under



the edges of the wound for some distance. Similar treatment was pursued as with the first ulcer and the slough had disappeared and granulation had set in when the patient went to Camp Taft. During his absence of ten days the legging on his right leg made several abrasions around the ulcer, all of which became infected and small superficial ulcers formed, which yielded readily to treatment, and the case was dismissed September 14th, 1908.

A section of the periphery of the first ulcer was examined by Dr. H. F. Harris as were several dressings, but no special organism was found.

Candler Building.

# EDITORIALS

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We will present, postpaid, on request, to each contributor of an original article, twenty (20) marked copies of THE JOURNAL-RECORD OF MEDICINE containing such article.

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## MEDICAL EDUCATION IN GREAT BRITAIN AND IRELAND.

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The British Medical Journal publishes annually a special "Educational Number," setting forth the regulations guiding the various schools of medicine and dealing generally with the position of medicine in the British islands.

These, as a matter of comparison, should be interesting reading to the profession in other countries.

"The practice of medicine in the United Kingdom, as in all other civilized countries, is regulated by the State, but in the case of Great Britain and Ireland the State has not proceeded by the direct road followed in the German empire, where every aspirant must pass an examination held by the State, the *Staats Examen*, before he has the legal right to practice. The Medical Act of 1858 called into existence the General Council of Medical Education and Registration of the United Kingdom, and entrusted to it the duty of keeping a *Medical Register*, laying it down that the words "legally qualified medical practitioner," "duly qualified medical practitioner," or any words importing a person recognized by law as a medical practitioner or member of the medical profession, when used in any Act of Parliament, shall be construed to mean a person registered under the Act. A valid medical certificate required by any Act of Parliament can be

given only by a registered person. Further, only persons so registered can recover in a court of law charges for medical or surgical advice, attendance or operation.'

"The Council has power to require any body granting a qualification for registration to furnish it with full information as to the course of study and examinations through which students must pass before obtaining the qualification in question."

"Official statistics published recently under the authority of the General Medical Council show that the mean length of the curriculum in the case of 1,111 students whose cases were investigated was three weeks less than seven years; only 14 per cent. succeeded in obtaining a qualification in the minimum period of five years, 33 per cent. obtained it in the sixth year, 18 per cent. in the seventh year, and 13 per cent. in the eighth year. When the remaining 20 per cent. obtained it does not appear, probably never. Looking at the figures in another way, we find that at the end of six years less than half of the number of students had obtained a qualification for registration and at the end of seven years only two-thirds. Those who took eight years constituted 13 per cent. of the total, or almost as large a proportion as those who qualified in the minimum period of five years.

The statistics in the three kingdoms, it is true, show considerable variations, 23 per cent. of the students in Scotland and 12 1-2 per cent. of the students in Ireland obtaining a qualification in the minimum period, whereas in England only a little over 7 per cent. were thus successful. Looking at the matter broadly, however, we shall not be far wrong in asserting that no student entering a medical school can expect to leave it with a qualification in less than six years, and that neither he nor his parents need be surprised if the period extends to seven years.

Aspirants to the ranks of the profession must give proof, before they are eligible to registration as medical students, of an "efficient knowledge" of at least the following subjects: English in its various branches, including history and geography, Latin, mathematics, including arithmetic, algebra and geometry, and either Greek or a modern language, and that they are at least 16 years of age.

It is only from the date which appears against his name in

the *Students' Register* that the medical student's career officially begins; thereafter five years must pass before he can present himself for final examination for any diploma which entitles its lawful possessor to registration as a qualified medical practitioner under the Medical Acts.

An academic year is divided into a winter and a summer session. The minimum 5 year period must be one of bona fide study, and during its course education in the following subjects must be pursued and examinations passed:

Physics, chemistry, biology, anatomy, physiology, materia medica and pharmacy, pathology, therapeutics, medicine, including medical anatomy and clinical medicine, surgery including medical anatomy and clinical surgery, midwifery (25 cases must be attended), gynecology, including diseases peculiar to women and new-born children, vaccination, forensic medicine, hygiene, mental diseases.

The regulations also generally necessitate definite study for stated periods of diseases of children, of the larynx, ear and nose, of the skin, of ophthalmology.

"A student to obtain a registrable qualification in the minimum period of five years, or fifty-seven months, must have a certain amount of good luck; in other words, he must keep in good health through every term, and never fail at a single examination."

One of the most striking differences between British and American regulations is observable when the question of degrees is discussed. In the United States, but not in Canada, it is, we believe, the universal custom to grant the doctorate to the student who has successfully passed his college examinations. In the British islands this is never done. These medical schools may be divided into universities and colleges, only the former granting the doctorate, and that to those alone who have undergone a farther period of probation, and passed some form of examination, at least one year after the Bachelor's degree has been taken at the termination of the ordinary student's career of 5 years or more. The colleges, such as the Royal Colleges of England and of Edinburgh, give memberships or licenses as evidences of the ability of their owners to practice medicine. These are ample for the purpose, and probably the vast majority of British practitioners possess no other diploma. But such as desire to show evidence of

more prolonged application proceed to take one or more of the higher diplomas.

Licentiates and members, as such, may proceed to take the fellowship of a college, a degree which is always convincing evidence, to those who know its value, of both ability and hard work. Bachelors have the advantage of being able to take not only the doctorate of their university, but also the membership and afterwards the fellowship of any of the colleges by merely passing their examinations without attending their classes. But the fellowship of the Royal College of Physicians of London is a purely honorary degree. Besides strictly medical diplomas there are others which have an important bearing on medicine, as for instance the Bachelor and Doctorate of Science in Public Health, or the Diploma in Public Health, one of which is expected of applicants for public health appointments, and each of which is obtainable only after a considerable period of study in the theory and practice of subjects relating to Preventive Medicine.

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#### TO IMPROVE MEDICAL EDUCATION AND MEDICAL PRACTICE LAWS.

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At a call meeting of the Regular Board of Medical Examiners on June 10, 1908, at Macon, Ga., there were present Drs. E. R. Anthony, J. B. S. Holmes, F. D. Patterson of the Board, Dr. G. H. Noble of Atlanta College of Physicians and Surgeons. The following questions were discussed and agreed upon:

First.—To increase the medical course to four years of at least six months each in four separate and distinct years.

Second.—That medical students in attendance upon medical colleges be allowed to stand examination at the end of the second year in histology, bacteriology, materia medica, chemistry and physiology before the Regular State Medical Examining Board if they have successfully passed these branches in the colleges they are attending, and this examination to be final if the required percentage of the Regular State Medical Examination

**Board is made.** If they fail to make the required percentage, they be allowed another examination after their graduation. A certificate from the dean of the college must be presented by each applicant.

**Third.**—That the Secretary of the State Regular Board of Medical Examiners be authorized to grant temporary license after satisfactory examinations by him.

**Fourth.**—To amend the law to authorize the State Regular Board of Medical Examiners to revoke licenses for cause.

**Fifth.**—The Regular Board of Medical Examiners be authorized to accept only applicants for examination who are graduates from colleges belonging to the American Medical College Association and the Southern Medical College Association, or other medical colleges that are recognized by the regular or mixed State Licensing Boards of their respective states.

**Sixth.**—That term of office of the members of the State Regular Board of Medical Examiners shall be four years instead of three.

**Seventh.**—Vacancies shall be filled on the State Regular Board of Medical Examiners as follows: Members of this Board, the President of the State Association and the Chairman of the Counsel shall present the names of three worthy and well qualified physicians for each vacancy to the State Association for their ratification, and from these names the Governor shall make the appointments.

**Eighth.**—That State Regular Board of Medical Examiners recommend to the colleges the preliminary educational requirements of a high school diploma or a second-grade teachers license furnished by the County School Commissioner.

E. R. ANTHONY, Sec'y.

J. B. S. HOLMES, Chairman.

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#### SOUTHERN MEDICAL ASSOCIATION.

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Again we would like to call attention to the next annual meeting of the Southern Medical Association which will be held in Atlanta November 10, 11, and 12, 1908. This meeting promises to be of much interest as it probably will have a larger attendance



than has had any southern meeting of the medical men heretofore.

Many excellent papers will be read and will demonstrate the careful scientific work being done in the South. No physician who can possibly come can afford to miss this meeting. Short papers with a point and lively discussions are earnestly desired.

Southern Passenger Association has authorized a rate of one and one-third fare, plus not exceeding 25 cents, from all points embracing in the Southern Medical Association east of the Mississippi river. (Rate west of the river will no doubt be the same.—Secretary.) Date of sale November 7, 8, 9, good until November 14, leaving Atlanta, with three days transit limit.

The following letter has been sent to Georgia physicians who are urged to attend this meeting:

DEAR DOCTOR:

The Southern Medical and Surgical Association will meet in Atlanta, November 10th, 11th, and 12th. As you probably know this association has already attained what it has intended to be, an association for the advancement of science and particularly to bring together the workers in the South.

The American Medical Association is so big and usually meets so far away from home that it does not furnish a medium for the exchange of ideas among the southern physicians and surgeons.

There is a great deal of splendid work being done in the South which does not receive a large southern audience. This association, then, will be the means of affording its members the opportunity to see and hear good work that will be a stimulus to better work, and what is not least, will furnish pleasant association with our fellows of the surrounding states once a year.

It is particularly desirable that Georgia should be well represented in the coming meeting in Atlanta. Every physician who is a member of the State Association is eligible to membership in this Association, and upon payment of the dues becomes a member. I wish, therefore to extend to you, in behalf of the Association, a most cordial invitation to be present at the meeting in Atlanta in November.

The members of the profession of Atlanta and looking forward with the greatest pleasure to this meeting, and shall be delighted to welcome you.

If you desire to join, kindly fill out the enclosed blank and make out a check for two dollars, payable to Doctor Oscar Dowling, Secretary, and send them both to me. I will forward the check to Dr. Dowling.

Very respectfully yours,

MICHAEL HOKE, M. D.

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COLLECTION DEPARTMENT OF THE FULTON COUNTY MEDICAL SOCIETY.

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Believing that the best interests of the medical profession could be promoted by a systematic effort to collect accounts from patients who were well able to pay the physician, but *would not*, the Fulton County Medical Society appointed a committee to consider the matter of arranging for such a collection. After much deliberation and many conferences with various prospective collectors, the committee finally settled upon the definite plan which is briefly stated in the following letter which has been sent to each member of the society, and explains itself.

Dear Sir: I beg to inform you that the "Collecting Committee" of the Fulton County Medical Society has made an arrangement with Mess. Napier, Wright & Cox, Attorneys, by which these gentlemen have agreed to handle the collections of our association on the following terms. Claims of \$5.00 and less, 50 per cent; \$5.00 to \$10.00, 25 per cent; \$10.00 to \$20.00, 20 per cent; \$20.00 to \$50.00, 12 per cent; and all claims amounting to over \$50.00, 8 per cent.

They have agreed to render statements on the first of each month to each doctor who places his claims in their hands, which statements shall make known the condition of the claims in their hands, such record to be the property of the secretary of the association.

They will also make up for the members who send in accounts, a list giving such information as may be desired.

Trusting that this may be of value to you, I am,

Very truly yours,

J. ROSS SIMPSON,  
Secretary Fulton County Medical Society.

The daily press soon secured the facts concerning the above plan of collecting bad accounts and gave considerable space to an exaggerated and hysterical description of the "dead beat list," "the doctors boycott," etc. The Atlanta Constitution finally dealt with the matter in a very sensible editorial which brought to a close the sensational features of the plan of the collection committee. The standard of the medical profession undoubtedly can be raised by making reasonable and systematic efforts to collect their accounts. To keep abreast the times, to buy new books, new instruments, office equipment and suitable conveyances, and to attend the various medical associations and post-graduate schools require not *much more* than *could* be collected, by the average physician, *above* his usual income. That better equipment and training will increase the physicians efficiency no one will gainsay, consequently the patient will not be a loser, but a gainer, by reasonably prompt payment, even though some effort on the part of the collector is required in making the settlement.

All physicians of Atlanta are urged to avail themselves of the reasonable rates of the collectors and the other advantages that will accrue from this plan.

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#### "MEDICAL CONSENSUS" SUSPENDS PUBLICATION.

#### THE JOURNAL-RECORD BUYS SUBSCRIPTION LIST.

The *Medical Consensus* has ceased publication, and hereafter the *Journal-Record of Medicine* will be sent to their subscribers, thereby carrying out the integrity of the subscription list of the *Medical Consensus*. We trust this arrangement will prove satisfactory to the friends of both journals.

## MILITARY SURGEON'S CONVENTION.

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The seventeenth annual meeting of the Military Surgeons was held in Atlanta, October 13, 14, 15 and 16, in the assembly rooms of the Piedmont Hotel, with the following officers officiating:

President, Assistant Surgeon General George Tully Vaughan, P. H. M. H. S.; first vice-president, Rear Admiral Presley D. Rixley, U. S. N.; second vice-president, Colonel Joseph K. Weaver, N. G. Pa.; third vice-president, Colonel William C. Gorgas, U. S. A.; secretary, Major James Evelyn Pilcher, U. S. V.; treasurer, Major Herbert A. Arnold, N. G., Pa.; assistant secretary, Captain J. Carlisle DeVries, N. G. N. Y.

In addition to the scientific meetings, at which many excellent papers were read on subjects of particular interest to military surgeons, there were public meetings at the State Capitol, a reception and ball at the Piedmont Driving Club, an automobile ride and a barbecue at the Atlanta Cue Club.

The Atlanta physicians felt highly honored to be able to entertain so many distinguished military surgeons and extended to them a hearty welcome.

Among the delegates enrolled upon the registration book were:

Colonel George Tulley Vaughan, Major James E. Pilcher, W. H. Marsh, Maryland; Colonel James K. Weaver, Pennsylvania; Major H. A. Arnold, Pennsylvania; Captain J. Carlisle DeVries, New York; Captain John Vernon Frazier, Michigan; Brigadier General F. Elbert Davis, New York; Colonel Alejandro Ross, Mexico; Lieutenant Colonel Jose Barbosa Leao, Portugal; Colonel George Brown, Georgia; Medical Director John C. Wise, Washington, D. C.; Lieutenant Colonel W. H. W. Elliott, Indian medical service; Major J. W. Duncan, Georgia; Captain C. B. Walls, Illinois; Lieutenant Colonel M. W. H. Russell, R. A. M. C. England; Major E. S. Bet, Canada; Brigadier General Charles C. Foster, Massachusetts; Lieutenant Colonel G. P. Marquis, Illinois; Major G. H. Halberstadt, Pennsylvania; Major James R. Nankeville, Indiana; Major T. W. Evans, Wisconsin; Captain George H. Hidershede, Wisconsin; Major Dan S. Burr, New

York; Major T. W. Halbert, Tennessee; Captain G. Morgan Muren, New Jersey; Major Henry Aaron Jones, Rhode Island; Colonel Joachein B. Weintraub, Illinois; Lieutenant Montifiax W. Houghton, Rhode Island; Gustavus M. Blech, Illinois; B. J. Weitinsprou, North Carolina; Brigadier Alexander I. Stone, Maine; Colonel John S. Edwards, Wisconsin; Surgeon W. T. Thackery, Illinois; Captain P. I. Butler, Massachusetts; Major Henry Allers, New Jersey; Lieutenant W. D. Lyman, Michigan; Major Thomas J. Sullivan, Illinois; P. M. Garrington, Surgeon U. S. P. H. and M. H. S., New Mexico; Major Charles B. Ewing, Georgia; Captain H. H. Tuttle, Illinois; Major Frank H. Holmes, North Carolina; Lieutenant Thomas F. Duhigg, Iowa; Major Erwin M. Fuller, Maine; Major J. W. Heany, Cuba; Major E. L. Martindale, Iowa; Captain B. F. Bradbury, Maine; Colonel J. B. O'Neill, Maine; Major J. F. Lynch, Virginia; Captain A. P. Kalliontzio, Illinois; Colonel F. S. Nicholson, Nebraska; M. H. Simons, medical United States navy, Pennsylvania; Major C. Lynch, Wisconsin; Captain S. H. Green, Georgia; Surgeon C. P. Wertenbaker, Virginia; Lieutenant Arthur R. Jarrett, New York; Major J. C. Minor, Arkansas; Lieutenant Colonel A. S. Stayer, Pennsylvania; Medical Director M. J. White, P. H. and M. H. S., Michigan; Colonel Valery Harvard, Washington, D. C.; Major George S. Crampton, Pennsylvania.

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## NEWS AND NOTES

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Rr. J. Cheston King has just returned from the Fenwick Sanatorium, Abbeville, La.

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Dr. J. H. McDuffie, of Columbus, Ga., made a short visit to Atlanta during September.

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Dr. Henry R. Slack, of LaGrange, was in Atlanta during September.

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Montreal will hold during the first two weeks in November

Dr. Leonard Smith, of Edgewood, Ga., is out again after his recent severe illness.

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Dr. L. C. Fisher spent a portion of September in New York and other eastern cities.

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Dr. Al Fowler is at his office regularly again after an extended tour of Europe.

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Dr. W. L. Champion is home again after a protracted stay in Europe.

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a tuberculosis exhibition for educating the people of that city in the most recent methods of combating this disease.

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The American Dermatological Association held its annual meeting in Annapolis and Baltimore, Md., September 24-26.

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Dr. Willis Jones has been appointed attending surgeon to Grady Hospital. Succeeding Dr. W. P. Nicholson, who recently resigned. Dr. Nicholson's resignation marks the close of twelve years continuous and useful service to this hospital.

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The approaching wedding of Dr. Ed. Crawford, of Atlanta, and Miss Gray, of College Park, on October 28th, is a social event of much interest locally, and to Dr. Crawford's many friends in the profession.

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Dr. Thomas Hall, of Macon, passed through Atlanta on his way home from New York. Dr. Hall has been away from his practice for some time, further equipping himself for his specialty, eyes, nose and throat.

The meeting of the Seventh Congressional Association of Medicine at Cartersville on the fourteenth of this month was both pleasant and instructive. Some very interesting papers were scheduled. Dr. McRae, of Atlanta, and Dr. T. D. Coleman, of Augusta, President of the Georgia State Medical Association, were among the expected visitors.

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The International Congress on Tuberculosis at the recent meeting in Washington, D. C., placed itself on record against Dr. Robert Koch's views that bovine tuberculosis rarely causes human tuberculosis. The following resolution, which was unanimously adopted, will tend to settle this question for a while at least:

"Resolved, That the utmost efforts should be continued in the struggle against tuberculosis to prevent the conveyance from man to man of tuberculosis infection as the most important source of the disease.

"That preventive measures be continued against bovine tuberculosis, and that the possibility of the propagation of this to man be recognized."

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#### HYPODERMIC TABLETS FOR USE IN DISEASES OF CHILDREN.

*Editor:*

Early in my pediartic practice I encountered a difficulty in connection with making from standard adult-dose hypodermic tablets, the modifications in dosage appropriate to infants and young children. One has either to divide the tablet up in a sort of hit or miss fashion or dissolve it in water and calculate the number of drops containing approximately the desired dose.

Either method is clumsy, inexact and furthermore, in the latter instance, takes the time that is more needed in the emergency of the case.

To obviate these difficulties I have had Mess. Sharpe & Dohme to make a list of tablets for hypodermic medication in which the dose of the drug or drugs has been made suitable to infants and young children.

I feel confident that this innovation will appeal to the profession and that they will find the tablets useful. There are few physicians, especially those concerned in the treatment of disease in children who have not at one time or another been hampered by the lack of such a convenience in their practice. The following is the present list of tablets in common use:

Morphine sulphate gr. 1-48, atropine sulphate gr. 1-1200.

Strychnine nitrate or sulphate gr. 1-360.

Atropine sulphate gr. 1-800.

Nitroglycerine gr. 1-600.

Nitroglycerine gr. 1-600, strychnine sulphate gr. 1-200.

In addition to the foregoing I have requested the manufacturers to make a tablet composed of morphine sulphate gr. 1-25 with atropine sulphate gr. 1-300. These can be divided in half, giving the dose usual in cholera infantum in an infant one year of age, that is: morphine sulphate gr. 1-50, atropine sulphate gr. 1-600.

SAMUEL A. VISANSKA, Ph.G., M. D.,  
318-319-320 Prudential Building.

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## FULTON COUNTY MEDICAL SOCIETY.

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CARNEGIE LIBRARY, AUGUST 6, 1908.

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REPORTED BY R. R. DALY, M. D.

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DR. STIRLING PRESIDING.

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*Dr. Archibald Smith* read a paper upon "Obstetrical Complications." He described at length the course of pregnancy and the parturition of a negro with a very small pelvis, whom he had advised to submit to Caesarian Section. Forceps were used, the child's head injured somewhat and the mother's perinaeum torn and her right leg partly paralyzed. He believed that though she went through labor contrary to his expectation, she and the child would have been better off and submitted to less risk if the operation had been permitted.

*Dr. Strickler* agreed that Caesarian section should have been



performed or premature labor induced because of the small pelvis. Also he suggested syphysiotomy because naturally there is often some separation at the pelvis arch. He reported in one case separating the pelvis successfully with the forceps.

*Dr. Oglesby* said that a doctor was warranted in not continuing with a patient who refused his advice as this patient did.

*Dr. Todd* spoke in support of the paper complimenting *Dr. Smith* upon his skill and fidelity to his patient under adverse circumstances.

*Dr. Smith* in closing said he could not agree that a doctor should not treat a case such as his because the patient would not follow his advice in every feature.

*Dr. T. Gillard* presented a paper "A General Consideration of the Epithelia Found in Urine and Their Differentiation as an to Correct Diagnosis."

*Dr. Willis Jones* disagreed with the essayist and said that no one could tell where the epithelium came from with sufficient definiteness.

*Dr Strickler* said he had recently tried it without success.

*Dr. Block* said the microscope is only an aid and that the clinical symptoms must be considered in connection with its findings. He agreed with *Dr. Jones* as to its incertitude.

*Dr. Todd* said that the paper illustrates one of the dangers of specialism. Many advances are made, or seem to be made, but we can't accept them all or depend absolutely upon them without danger.

*Dr. Gaillard* replying, referred to many German investigators who claim to make the differentiation all along the uriniferous tract and prove them later by the clinical symptoms.

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#### REGULAR MEETING FULTON COUNTY MEDICAL SOCIETY, AUGUST 20, 1908.

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*Dr. P. Calhoun* exhibited a case of frontal sinus trouble due to a blow in March, 1907. Cerebral symptoms followed and partially subsided but severe pain continued. A nasal polyp gave

a clue to the trouble and transillumination showed a shadow in the right minence. The X-ray showed a large sinus extending past the middle line. He operated May 26, 1908, and tried to establish drainage through the nose, but was unsuccessful. External drainage was made and the sinus filled with healthy granulations nicely. Only a small scar remains and practically no deformity. Headaches all disappeared and patient is comfortable in every way.

*Dr. Calhoun* also exhibited a case of rapidly growing carcinoma in the tongue of a negro.

*Dr. Claude Smith* gave his paper on the "Diagnosis of Diphtheria."

*Dr. Daly* in discussion complimented *Dr. Smith* upon the good work the health board is doing along this line and noted the convenience with which culture tubes could be secured. He suggested that the throat applicators should be made of some flexible material so that smears could be obtained from the naso-pharynx and the larynx which can not be done with the straight swab.

*Dr. P. Calhoun* spoke of the cause and treatment of diphtheria and noted that negroes do not have it probably because they are better nose breathers than the whites.

He said that conjunctival smears made before cataract operations often showed pseudo-diphtheritic germs that were of the same family as the Klebs-Loeffler bacilli.

*Dr. Block* said he had cases of persistent bacilli several months after the patient seemed well. One child had five attacks three months apart which he believed were due really to the one infection never completely removed.

*Dr. Willis Jones* asked about the curative effect of antitoxin.

*Dr. Oglesby* asked what was the proper time for injections.

*Dr. Armstrong* stated that the third day was the latest date at which antitoxin was affective and added that deaths came after the 14th day.

*Dr. Boynton* said that recent antitoxin seemed weaker than the older ones. formerly 4,000 units used to be enough, now 12,000 to 24,000 are needed. He thinks we are inclined to wait too long for the second dose. The pain after each injection is pitiful, yet they should be repeated after 8 hours.

*Dr. L. B. Clark* said he never saw any harm from antitoxin. He uses it at once and gave 20,000 recently with good results.

He added that we don't keep children quiet long enough. They get out to play and infect other children before their throats are clean.

*Dr. Duncan* spoke of the importance of the clinical symptoms and said the case was diptheria whether the cultures showed bacilli or not, if the clinical picture was such as to indicate it. Antitoxin has never done any good in his hands.

*Dr. Block* said the formation of the membranes is not directly due or necessarily dependent upon the bacilli, and that careless smearing is not efficient to find the germ. This explains many of the slips in diagnosis by the culture tube. He would rely upon bacterial signs more than upon the clinical, but if the later were present, he would not wait 24 hours for the culture before giving the antitoxin.

*Dr. Stirling* commended *Dr. Smith's* paper and agreed with *Dr. Clark* upon the importance of continued rest for the child.

*Dr. Smith* closed by asking that smears be carefully taken beneath the membrane if possible. Cases in which no germs appeared in this way were not diptheria even if there were membranes an prostration. He hesitates to give antitoxin as a prophylactic because there have been sudden deaths from its use in this way. He advises the use of antitoxin when case is profoundly intoxicated even before laboratory report.

*Dr. Block* read his paper upon "Exophthalmic Goitre." Discussed by *Dr. LeConte*.

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#### REGULAR MEETING FULTON COUNTY MEDICAL SOCIETY, SEPTEMBER 3, 1908.

*Dr. Hoke* reported a case of sacro-illiac dislocation illustrated with skiagrams. Several other diagnosis had been made, but the shadow finally showed the trouble clearly. The right ilium was pushed backward out of place. The literature on this subject is scarce and practically nothing is said about method of reduction.

The femur was used as a level to force the ilium into place while the pelvis was fixed and patient lying on left side. Plaster of Paris cast applied over hip and half way up the chest. Pain of five years duration was promptly relieved.

*Dr. Hoke* reported a case of toxic arthritis of the finger joints in which there were spindle shaped fingers due to deposits in the joints. The points were opened, fibrous tissue and some bits of bone removed with excellent results. Skiagrams illustrated the conditions before and after operation.

He used cocaine, but would prefer a general anaesthetic in another similar case.

*Dr. C. R. Andrews* read his paper upon "The Treatment of Liauses by Bismuth-Vaseline Injection."

*Dr. Lockey* asked as to its value in frontal sinuses.

*Dr. Goldsmith* related three cases, one a fistula in the sacrum and the third with no bone involvement in the axillary region all of which were greatly benefited by this injection.

*Dr. Roy* asked for indication for second injection.

*Dr. Hoke* spoke of the simplicity of the procedure.

*Dr. Andrews* replied saying that Beck reports a case of cure of antrium disease. There is no good reason why it should not be used in any sinus. The second injection may be given at the end of a week and repeated as often as is necessary. The bismuth not only forms trabeculae upon which granulations may be supported, but it is rendered radio active by the X-ray and stimulates healing. Vaseline should be used instead of albolene.

*Dr. L. M. Gaines* read a paper on "The Practical Value of Blood Examinations."

*Dr. Paulin* discussing said the blood examination taken alone was of less value than many supposed. He told of a case of typhoid running ordinary course. Then temperature went to 107.2, Lencocytes 6000, Polymorpho-nuclear Lencocytes 50-60% Perforation was suspected. No operation was done however. Chills recurred in 4 days. It developed patient has hernia and staphylo coccus aureus caused chill.

In two other cases the lencocyte count showed perforation before the clinical picture indicated it.

He agrees with essayist in his conclusions as to lenkoemias and penucious anaemias where the examination is most valuable. He related three cases of leukoemia mistaken for pregnancy in which blood examination cleared diagnosis. The haemolytic property of the blood in carcinomas is attracting attention and he looks for developments along that line.

*Dr. Claud Smith* agreeing with the essayist, mentioned the

facial color of the cases as often being confusing. A rosy hue sometimes takes the place of the yellow of jaundice. An examination may show anemia here.

*Dr. Armstrong* told of operation upon a case of gangrenous appendix because the blood indicated it while the general symptoms did not.

*Dr. Gaines* replied and closed saying that constant practice was necessary to complete the technique. He laid stress upon the value of the differential count.

*Dr. Claude Smith* addressed the society in the interest of an ordinance to go before the City Council in relation to preventing the propagation of flies. All refuse, manures, etc., are to be properly cared for. The Society gave its indorsement to the measure.

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#### REGULAR MEETING FULTON COUNTY MEDICAL SOCIETY, SEPTEMBER 17, 1908.

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*Dr. Huguley* exhibited a thyroid gland removed a week ago. The goitre was of the exophthalmic type and displayed many toxic symptoms. These disappeared with the removal of the gland.

*Dr. Harris* gave an exhaustive paper on "Sprue."

*Dr. Todd* said he has seen cases of sprue without recognizing them because the investigations made by *Dr. Harris* had not then been given to the profession.

*Dr. J. L. Campbell* agreed with the essayist in the value of early diagnosis of this disease and related some distressing cases he had seen.

*Dr. Harris* in closing said that there was much pellagra in Georgia and that it closely resembled sprue at first. All such cases should receive special attention in the reasonable hope preventing the disease and eventually of getting rid of it.

*Dr. Roy* read on the subject "Exploratory Puncture of the Membrane in Certain Diseases of the Middle Ear."

*Dr. P. Calhoun* could not fully agree that puncture should be

made when for exploratory purposes only. He wanted more indications than Dr. Roy had presented. He feared turning a case of catarrhal trouble into a furulent one.

*Dr. Wheeler* agreed with Dr. Roy as to the usefulness of the puncture.

*Dr. Daly* agreed with Dr. Roy and added that the membrane should be incised much more frequently than it is in cases of children who were in great pain and who would not permit of other measures of relief. The pain disappeared and there was much less likelihood of pus than if the secretions were left to make their own opening.

*Dr. Stirling* complimented Dr. Roy upon his paper and agreed with him essentially.

*Dr. Roy* in closing said that he never had much difficulty after paracentesis and he thought the laity ought to be instructed that puncture of the drum membrane did *not* mean deafness as many of them suppose.

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## BOOK REVIEWS

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PROGRESSIVE MEDICINE, VOL. III, SEPTEMBER, 1908.

A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medicine in the Jefferson Medical College of Philadelphia. Octavo, 287 pages, with 30 engravings. Per annum, in four cloth-bound volumes, \$9.00; in paper binding, \$6.00, carriage paid to any address. Lea & Febiger, Publishers, Philadelphia and New York.

The September volume of *Progressive Medicine* deals helpfully with four topics of great practical importance.

Under the title of Diseases of the Thorax and its Viscera, Professor Ewart gives an admirable summary of the recent advances in our knowledge of tuberculosis. The treatment of emphysema, the associated disturbances which may arise in dis-

orders of the heart, blood pressure and its relation to disease are topics with which the author has dealt in a manner which will command special attention.

Dr. Gottheil's contribution, covering Dermatology and Syphilis, possesses much of interest, even for those whose practice lies outside the lines of these subjects. In particular, we would allude to his views as to the use of carbon dioxide in the treatment of nevi and other growths and to the sections devoted to the uses and limitations of the x-rays in diseases of the skin. The general resume devoted to Syphilis is excellent.

The advance in our knowledge of Obstetrics has been very completely covered by Dr. Davis. Among the topics in his contribution, which possesses more than ordinary interest, may be mentioned changes in the various organs of the body produced by pregnancy, eclampsia, ectopic gestation, face presentation, narcosis during labor, pubiotomy and the management of the third stage of labor.

The department of Nervous Diseases concludes the volume. The author, Dr. William G. Spiller, has produced a very complete and lucid review of the advances in this rather abstruse department of medicine, as is especially apparent in his treatment of the subject of brain tumors and locomotor ataxia.

Progressive Medicine occupies a field apart from that of the magazine. It performs for the general practitioner, the surgeon and the specialist a most important service, bringing him knowledge which he could not otherwise obtain, either by his own efforts or in any other publication.

Most of the advances in medicine are of course first announced in periodicals as the quickest means of publicity. Many of them are lost to the man who does not read a half dozen languages, and this vital knowledge would moreover be limited to very small circles were it not for the existence of this medium for universal diffusion.

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ANATOMY, DESCRIPTIVE AND SURGICAL. By Henry Gray, F. R. S., late lecturer on Anatomy at St. George's Hospital, London. New American edition, enlarged and

# Journal-Record of Medicine

Successor to Atlanta Medical and Surgical Journal, Established 1855.  
and Southern Medical Record, Established 1870.

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VOL. X.

NOVEMBER, 1908.

No. 8

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## LONG AND HIS DISCOVERY.

BY I. H. GOSS, M. D., ATHENS, GA.

We have been taught that medical operations have been tempered by forms of anaesthesia "since the days whereof the memory of man runneth not to the contrary." The suggestion has been made that the "deep sleep" that the Creator "caused to fall upon Adam" was the germ idea of anaesthesia. There are traditions that the Assyrians employed digital compression of the carotid arteries to produce anaesthesia; also that the Egyptians used Indian hemp and the juice of the poppy to cause drowsiness before surgical operations.

The Odyssey informs us that a "sorrow easing drug" was given by Helen to Ulysses. The younger Pliny describes the use of mandragora as a narcotic, and Galen speaks of its power to paralyze sensation. In the twelfth-century in Celtic manuscript



on materia medica mention is made of a draught which was used by the early Irish to induce sleep; and in the fifteenth century, on occasions of surgical operations, patients were put to sleep by means of that which was termed "The Sleeping Sponge." Reginald Scott, in the sixteenth century, wrote of an anaesthetic made of opium, mandragora bark, and henbane root; and Shakespeare's references to "drowsy syrups" are proverbial. Opium as an anaesthetic—both by inhalation and by internal administration—is declared to have been used in the eighteenth century, and during the same period other means of producing insensibility were suggested.

It were a work of supererogation for me to remind this distinguished presence of the brilliant discoveries in chemistry which created a new epoch in the history of anaesthesia; first, the discovery of Priestly, which led to administering gases and vapors by inhalation; then followed the experiments of Beddoes; the researches of Humphrey Davy on nitrous oxide; the inhalation of sulphuric ether, by Woolcombe, of Plymouth; and the conclusion of Faraday, in 1818, that the vapor of sulphuric ether produced similar effects to those caused by nitrous oxide. All of these valuable discoveries are now as a tale oft told, as is also the fact that Professor Thompson, of Glasgow, amused his students by occasionally permitting them to inhale ether and nitrous oxide until they became unconscious and appeared to be insensible to pain.

Says a well-known writer upon the subject of anaesthesia: "It is extraordinary that among all the investigators who for so many years stood upon the very brink of a great discovery, no one ventured over the threshold."

That the practical understanding of anaesthesia finally came, and same in an unexpected, indirect way, if such knowledge may ever be called indirect, is known to all within the sound of my voice. It is my privilege and my pleasure today to memorialize the great discoverer of anaesthesia, both because of his valuable work, and because the United States, the State of Georgia, and our medical association may claim him as their own.

On the first day of November, 1815, Crawford W. Long was born in the State of Georgia, in the village of Danielsville, a place of such modest proportions as to merit the affirmation of Washington Irving when he said: "Genius loves to bring

forth her offsprings in by-corners. She seems to delight in disappointing the assiduities of art, and to glory in the vigor of chance productions. She scatters her seeds to the winds, and though some may perish among stony places, others struggle bravely up into sunshine."

The ancestry of the discoverer of anaesthesia was highly respectable. His paternal grandfather, Captain Samuel Long, of Pennsylvania, distinguished himself during the Revolutionary War; he was one of General Lafayette's officers at Yorktown, and saw the independence of his country triumphantly established. He moved to Georgia, and here his son, James Long, became a superior scholar, a profound student of the law, was for years a member of the Senate, and was regarded as one of the prominent men of the commonwealth. James Long was an intimate friend of Georgia's great statesman, William H. Crawford, and as a result of this friendly relation he gave to his first born son the name of Crawford.

If it were possible to penetrate the remote and occult sources of character and temperament as they are transmitted from one generation to another, perhaps we might trace the force and beauty which governed the life of Crawford W. Long, to the enduring impressions stamped upon his imagination by the sentiments of his distinguished parentage.

Be that as it may, he certainly had no cause to be ashamed of his ancestry. We have no superstitious veneration for that which is termed "blue blood," especially when it is the reproach of degenerate offspring, but we very properly rejoice with the man who can trace his descent from an honored line.

Crawford W. Long early displayed signs of unusual ability. His primary education was quickly accomplished, and he matriculated at Franklin College—now the University of Georgia—at a peculiarly early age, graduating from this institution when only nineteen, standing second in his class, and receiving the degree of Master of Arts. After studying for one year at the University of Pennsylvania, he was graduated from that renowned institution, where he had largely and successfully devoted time to experimental work. He then spent a year in New York, and while there attained reputation as a skillful surgeon.

In 1841, because of family importunities, Crawford W. Long returned to Georgia. He began the practice of medicine in the

village of Jefferson, far from the bustle of the great world, remote from railroads and other necessities of modern life, truly a "nestling place for genius."

Dr. Long, albeit, yet a young man, soon acquired an extensive practice. His abilities were apparent. His quiet, thoughtful bearing attracted people to him. It may be declared that there was more in his *silence* than in the *words* of many men. Throughout life Dr. Long was one of those men whom, according to George Eliot, "we can best know by entering with them their homes, and hearing the voice with which they speak to the aged and young about their hearthstone, and witnessing their careful thought for the everyday wants of everyday companions," He bore a fine character, and "character," says Phillips Brooks, "is like a bell which rings out sweet music, and which, when even accidentally touched, resounds with music."

It was apparent to both old and young that Crawford W. Long had come into the world to better his fellow creatures. His office became the place of sojourn of those who desired a pleasant evening, especially of the young men of the village. About that time the inhalation of laughing gas, as an exhilarant, was much discussed. Lecturers on chemistry would sometimes entertain by giving a "nitrous oxide party," during which the participants would become drunk from its inspiration. It was in the winter of 1841 that some young friends importuned Dr. Long to permit them to indulge this pastime in his office. The physician had no means of preparing nitrous oxide gas, but suggested that sulphuric ether would produce similar exhilaration. The ether was produced; the young men inhaled and became hilarious. During the period of mirth some of them received bruises. The young medical practitioner noted that these bruises were not accompanied with pain. In consequence he divined that ether must have the power of rendering one insensible to pain, and from this simple observation came the great discovery of anaesthesia.

Just here it may not be improper to remind ourselves that many of the brightest achievements of science are the results of slight observations, as the incident of Sir Isaac Newton and the falling apple proves. We are taught that the art of printing, probably the parent of more good than all others, owes its origin to rude impressions taken from letters carved on the bark of a beech tree—so trivial a matter that thousands would have passed

it over with neglect. We are taught that the stupendous results of the steam engine may be traced to the chance observation of steam issuing from a bottle just emptied and placed casually near to a fire. We are also taught that electricity was discovered by some one noticing that a piece of rubbed glass attracted bits of paper. Every one now appreciates the importance of these wonders, yet they were the results of slight observations.

"Nothing is too little for the attention of man," says an old maxim upon the walls of the workshop of Peter the Great. The thoughtful subject of this paper found nothing in his profession too small for careful attention. He promptly determined to prove the value of his discovery, and during the month of March, 1842, ether was administered to Mr. James Venable until he was completely anaesthetized, then a small cystic tumor was taken from the back of his neck. To the amazement of the patient he experienced no pain, and surely this was complete anaesthesia. From five to eight other cases, testing the anaesthetic power of ether, were satisfactorily dealt with by Dr. Long during the years 1842 and 1843—quite a goodly number when it is remembered that surgical operations were not frequent in the country practice of a young physician more than half a century ago.

Dr. Crawford Long's surgical operations, under ether, were exhibited to medical men and also to persons of the community, as established by affidavits of persons operated upon, and of witnesses to the operations. Says Ange De Laperriere, M. D., of Jackson County: "I do certify that the facts of Dr. C. W. Long using sulphuric ether by inhalation to prevent pain in surgical operations, was frequently spoken of and became notorious in the County of Jackson, Georgia, in the year 1843." In May, 1843, Drs. R. D. Moore and Joseph B. Carlton, for many years leading physicians in the city of Athens, Georgia, discussed the trial of Dr. C. W. Long's discovery in a case of surgery before them. They were unfortunately prevented from making the experiment by having none of the fluid at hand. Mrs. Emma Carlton, widow of Dr. Joseph B. Carlton, who died recently in Athens after living here for many years, signed the following: "I do certify that Dr. Crawford W. Long, of Jefferson, Jackson County, advised my husband, Dr. Joseph B. Carlton, a resident of Athens, Georgia, to try sulphuric ether as an anaesthetic in his practice. In November or December, 1844, in Jefferson, Geor-

gia, while on a visit to that place, in the office of Dr. Long, my husband extracted a tooth from a boy who was under the influence, by inhalation, of sulphuric ether, without pain—the boy not knowing when it was done. I further certify that the fact of Dr. Long using sulphuric ether, by inhalation, to prevent pain, was frequently spoken of in the County of Jackson at this time, and was quite notorious.”

It is to be regretted that Dr. Long did not *at once* make known to the world his great discovery of anaesthesia. Considered from a present point of view, his delay seems extraordinary. But it must not be forgotten that since that period the world has moved with exceeding rapidity. Sixty-five years ago, for a young medical practitioner in an obscure village, far from contact with centers of thought, removed from railroads, enjoying but modest postal facilities, with no great hospital organizations or medical associations to confirm his professional research, for a modest, diffident, young physician to claim so startling a discovery as anaesthesia has proven to be, without first securing most exhaustive proof of its worth, would have brought upon him the adverse criticism of his elders, and possibly the laughter of his colleagues.

Dr. Crawford Long as a young man, in his maturity, and when “nearing life’s last white milestone,” was ever a modest, unassuming gentleman. He sought no vain publicity. He fostered no extravagant aspirations. He was only a wise, patient, careful seeker after truth. He worked and waited, resolving to make the most comprehensive report of his discovery, after testing all kinds of cases. His great work was slowly stealing forth and beginning to perform its beneficent and beautiful office, but he, the author, was standing quietly back in the shadow. He was hoping much, but at the same time was ruling himself, thereby meeting the application of John Milton’s words when he said: “He who ruleth himself is more than a king.”

Had Dr. Crawford Long promptly made known the results of his experiment it would have assured the distinguished honors to which he was entitled, and would have prevented long-continued controversy as to who was really the discoverer of anaesthesia. A careful examination of the question clearly shows that two and a half years elapsed after the discovery by Crawford W. Long, before Dr. Wells, of Hartford, knew the anaesthetic

power of nitrous oxide; that four and a half years passed after Dr. Long's initial experiment before Dr. Morton claimed to have the same knowledge. Morton is declared to have received the suggestion from Jackson; the latter claims to have made the discovery about the time Dr. Long made it, but left it to Morton to practically prove. Says Hugh H. Young, of Johns Hopkins Hospital, in his interesting pamphlet entitled, "Long, the Discoverer of Anaesthesia," "The immediate and universal use of anaesthesia in surgery is due to the great Boston surgeons, Warren, Hayward and Bigelow."

In 1849, Morton petitioned Congress for a reward as the discoverer, but he was opposed by the friends of Wells and Jackson. The friends of Morton and Wells presented volumes of testimony to the Senate of the United States in behalf of their candidates, but Jackson afterwards acknowledged the justice of Dr. Long's cause. For five years Crawford W. Long refused to take any part in the controversy. Never, indeed, did he ask pecuniary reward, but he naturally desired to be recognized as the discoverer of anaesthesia, and to that effect wrote an article for the Boston Medical Journal.

Confronted by so formidable an opponent as Long, the friends of Morton and Wells finally seemed to lose hope, the bill before Congress was allowed to die, and it was never resurrected. In 1877, Dr. J. Morton Sims investigated the claims of Dr. Long to the discovery of anaesthesia, and was convinced of their merit. He demanded their recognition by the medical profession, Dr. Long especially desiring the endorsement of the American Medical Association. It was but a short time afterwards that Dr. Long died, on the 16th day of June, 1878, in the city of Athens, Georgia, for many years the place of his residence.

The "Eclectic Medical Association" soon passed a decree in favor of Long, as did a number of minor societies; and Dr. Henri Stuart, founder of the Woman's Hospital in New York, presented a portrait of the discoverer of anaesthesia to the University of Georgia. A report has been circulated that a statute to the honor of Dr. Long has been placed in the City of Paris, France, but I am not informed as to the accuracy of such report.

Georgia has all along recognized Dr. Crawford W. Long as the discoverer of anaesthesia, and when Governor Alexander H. Stephens was requested to name two great Georgians whose por-

traits might hang in the National Gallery, he designated Oglethorpe and Long. Thus Georgia has recognized her distinguished son, but Georgia has been slow, very slow, in paying *all* of the tribute due her renowned dead, for the memory of this son has not yet been perpetuated in marble or bronze. The village of his birth, the other village which was the scene of his discovery, the town of his long residence and now custodian of his remains, the State Medical Association, the State University, the State herself, have yet failed to erect a public memorial to Crawford W. Long. The neglect has been unfortunate, and it should be quickly remedied.

To preserve the memory of those who have conferred great benefits, is both a privilege and a duty. To honor the illustrious dead is to stimulate the living to higher ideals and loftier ambitions. It is a usage sanctioned by the wisdom of many ages of civilization. A Southern orator has said: "The city of ancient Athens was full of the memorials of actual history. Every street and square from the Piraeus to the Acropolis were adorned with statues of great men of the commonwealth, and twenty-one centuries have not extinguished this sentiment of veneration for the illustrious dead. Memorials of such men are to be found in every civilized land. On the banks of the Danube there stands a noble marble structure, called the Hall of Heroes, filled with effigies of the great sons of Germany. By the soft blue waters of Lake Lucerne stands the Chapel of William Tell. In the black aisle of the old cathedral at Innspruck, the peasant kneels before the statue of Andreas Hofer. In her senate hall England bids her sculptors still to place the images of her noblest sons. Two hundred years after the death of Shakespeare a monument is erected to honor him, though his own works had already immortalized the name. Even now plans are being made for erecting a building in Washington City to memorialize Thomas Jefferson. The memory of Dr. Benjamin Rush is perpetuated in stone: and everywhere we may find similar tributes to the great men of various callings. In the City of Washington rises a monument to the Father of his Country—this great American republic of ours.

Gentlemen of our Georgia Medical Association, let us not defraud *our* illustrious deed of their rightful memorials. Let us wait no longer to proclaim by noble, beautiful and enduring art, this one of our number who gave an unsurpassed gift to his pro-

fession and to the world.

We are to be congratulated that some have not been so un-mindful as we, concerning this obligation, for a gentle reminder of our duty has quite recently come to us from that distinguished body, the State Federation of Women's Clubs—an organization that today a most potent factor for good in things educational, industrial and beautiful.

The Athens Chapter of the Federation of Women's Clubs has gladly undertaken the task of collecting an amount sufficient to erect a monument in honor of Dr. Long. This monument is to be at Athens, where repose the remains of the great discoverer, and will be erected in the name of the Medical Fraternity of Georgia. It is the earnest desire of those interested in this admirable undertaking to have a monument ready for unveiling during the gathering of our Medical Association at Athens in 1909.

Let us not prove forgetful of our interest in this memorial. In conformity with the usages sanctioned by ages, in conformity with the custom of our own time and our own country, in conformity with loving remembrance for our distinguished dead, let us unite our energies with those who are cheerfully and happily preparing to perpetuate in marble or bronze the memory of Crawford W. Long, the great discoverer of anaesthesia. Then may we exclaim with the poet:

"Patriots have toiled and in their country's cause  
Died nobly. And their deeds, as they deserve  
Receive proud recompense. We give in charge  
Their name to the sweet lyre. The historic muse,  
Proud of the treasure, marches with it down  
To latest times; and sculpture in her turn  
Gives bond in stone and ever-during brass  
To guard them and immortalize her trust."



## SHOULD THE APPENDIX BE REMOVED IN ALL CASES WHERE THE ABDOMEN IS OPENED FOR OTHER CAUSES?

BY L. C. FISCHER, M. D.

In presenting this subject to this Association I fully realize that it is one of great importance, and one that should be thoroughly considered by the operator and by the Medical Profession. I realize that all of the organs must have some function. It is a much mooted question as to what is the function, if any, of the appendix. Different writers having different opinions. About 1847 the function of the appendix was supposed to be that of secreting fluid which kept the contents of the cecum in a fluid or semi-fluid state. From that date to the present date different functions have been attributed to it. At the present time the best authorities think that the appendix has no function, or at least no function that seems to be disturbed by its removal.

It has been my experience, that in most cases where the appendix was removed, either as the primary operation or as secondary to the opening of the abdomen that the patient has invariably been in better health. This, of course, could not be attributed entirely to the removal of the appendix where that was not the conditions will cause this improvement in health. In no case do primary operation. Of course the removal of other pathological conditions will cause this improvement in health. In no case do I know of, where removing the appendix has caused any bad effect or change in health for the worse, except in two cases where adhesions were formed, due possibly to the lack of closing over the raw surface with peritoneum, or where there was acute inflammation. On the contrary I do know of cases where the appendix was not removed at the time of opening the abdomen, where shortly afterwards it was necessary to re-open the abdomen on account of the inflammation of this appendage. Two cases that have occurred in my own work within the last four years. For the last two years it has been my rule to remove the appendix when I opened the abdomen for other causes, where the condition of the patient would allow this extra procedure. The operation is done in a very few minutes and saves the patient the possibility of opening the abdomen at another time.

The cases above referred to are as follows:

Mrs. C., age 40, upon whom I did a pan-hysterectomy, closing over all of the raw surface, except on the extreme right angle of my incision, where I had cut through the broad ligament. About three months after the first operation I was called to see her in a acute attack of appendicitis, she at that time refused surgical interference, but after the third attack allowed me to open the abdomen. Upon opening it I found the appendix very long and adherent over the entire length of the cicatrix, caused by the removal of the uterus. Upon dissecting this out and removing the appendix the patient made an uneventful recovery.

The second case, Miss C. Where I had removed the right ovary and suspended the uterus. After this operation the patient had a rising temperature for a few days and some adhesions were formed around the stump. Nine months later I was called to see this patient with an acute attack of appendicitis, operated within the first 12 hours, found the appendix with its distal end adherent by adhesions to the stump where the ovary had been removed.

These two cases and their severity fully demonstrate the dangers of adhesions of the appendix where work has been done in the pelvis.

During the last 12 months it has been my privilege to see Dr. H. C. Coe, of New York do quite an amount of surgery and I do not remember in a single case where he did not remove the appendix, where the condition of the patient would allow. Dr. John B. Deaver, of Philadelphia after completing his primary operation looks up at his audience and says in a matter of fact tone, "Now, gentlemen, to complete this operation I will remove the appendix."

In order that I might present this subject to you from both sides I have written to some of the most noted surgeons of this country for their rules, the following questions were asked:

(1) Do you remove the appendix if you open the abdomen for any other cause?

(2) Have you had to re-open the abdomen for appendectomy upon patients who you had operated for other causes, if so did you find any adhesions around the appendix that you thought could be due to previous operations?

(3) Do you know of any change in health in patients in

whom the appendix has been removed, where the appendix was not the primary cause of the operation?

To these I have received the following replies: Dr. E. C. Davis, Atlanta, Ga.

(1) Yes, if the patients' consent is gained and her condition justifies the additional operation.

(2) Yes, in a number of instances with marked adhesions around the appendix.

(3) Yes, I believe in a number of instances the general health of the patient has been improved, and I recall no instance any ill effect from the removal of the appendix."

Dr. Joe Pierce, of Philadelphia:

"(1) Yes.

(2) Yes.

(3) Yes, improved. The appendix is a faulty piece of anatomy, always charged with the intestinal flora and never healthy. Ten or more per cent. of pelvic suppurations are complicated by the appendix and head of the cecum. It is often overlooked post operation complications and some deaths, or re-opening necessary."

Dr. Geo. H. Noble, Atlanta, Ga.

"(1) I do if the appendix is diseased or mutilated, otherwise do not remove it.

(2) Have operated on cases done by other surgeons, histories unsatisfactory, adhesions variable.

(3) No. Removal of healthy appendix does not seem to cure any thing."

Dr. John A. Wyeth, New York:

"(1) Never, unless diseased.

(2) Never.

(3) No. The proportion of diseased appendices is so small that its removal in the course of an operation for other cause than appendicitis is, in my opinion, scarcely worthy of consideration. If the operation were in the immediate neighborhood of this organ, and its peculiar structure and location should convince the operator that it was more than ordinarily susceptible to disease, it might justify its removal. However, no severe operation should be prolonged by the removal of an appendix not diseased."

Dr. Howard A. Kelly, Baltimore:

"(1) Always, if any suspicions of disease or if the patient requests it.

(2) In several instances; see my work on diseases of the Vermiform Appendix. Look for case under Hunter McGuire's name, etc.

(3) Have never known any bad effects from removing the appendix; in many instances an unsuspected disease of the appendix has been a source of trouble. In conclusion, I do not believe in removing the appendix in every case, but I do believe in widely extending the limits of this simple operation."

Dr. Howard J. Williams, Macon, Ga:

"(1) If there is any indication of removal of the appendix, during other abdominal operation—I do not hesitate in doing so; in every abdominal operation, before closing the abdomen I examine the appendix, finding adhesions or other conditions which would make it advisable to remove it, I do so before closing the abdominal wound.

(2) I cannot recall such a condition.

(3) No; if the patient were not told that the appendix had been removed, I doubt that he or she could ever discover any change or symptoms."

Dr. W. T. Bull, New York:

"(1) Usually in hysterectomy or operations of right broad ligaments.

(2) No. Have had several cases of acute appendicitis following hysterectomy or other operations where adhesions of appendix seemed to be the cause of the inflammation.

(3) No."

Dr. John B. Murphy, Chicago:

"(1) I do not remove the appendix in every abdominal operation, only when the appendix shows evidence of existing disease or that it has been previously inflamed. I examine the appendix in every laparotomy.

(2) Once only, one week after the extirpation of a fibroid. It was acutely infected and gangrenous.

(3) I know of no case. Do not attribute improvement of patients to remove a appendix where appendix was not found to be actually diseased."

Dr. H. C. Coe, New York:

"(1) Yes.

(2) Yes.

(3) Intestinal fistula in one case."

Dr. Robt. T. Morris, New York:

"(1) Leave the appendix alone until it is infected, and then lose no time in having it inspected.

(2) I can recall two or three cases in which adhesions following previous pelvic work seemed to have been influential in the development of appendicitis later.

(3) No unfavorable change in health in my own patients, so far as I know, but on the contrary most satisfactory changes for the better. It may be that patients with unfavorable results do not return to me for report. I make this comment for the reason that very many patients operated upon by others come to me for repair of hernas and separation of adhesions. The mere fact of absence of the appendix has no bearing because it is abscess in most elderly people, and in patients who have had distinctive inflammation of the appendix."

You will see from the best authorities that a great many of them do remove the appendix and especially so if it shows the least evidence of inflammation. Dr. Robt. T. Morris calls attention to the fact that the appendix is atrophied in old people and also to the absence of the appendix in distinctive inflammation. Several times on opening the abdomen have I found what Dr. John B. Deaver chooses to term "Suppurative amputation." This condition is the result of previous inflammation and results in a complete occlusion of the lumen of the appendix with subsequent atrophy. In these cases the patient gives a history of repeated previous attacks and invariably agrees to have the appendix removed for fear of at some future time they may have another attack. I believe the time is not far distant when the majority of the operators will consider it their duty to in all cases remove the appendix, where the conditions of the patient will allow and where there is no suppurative inflammation.

I have watched the patients upon whom I have operated for the last two years, where it was possible for me to do so, and no single instance have I found that they have suffered any ill effect from the removal of the appendix, to the contrary I believe they have been materially benefitted.

## RECIPROCITY BETWEEN STATES.

BY A. A. KENT, M. D., LENOIR, N. C., PRESIDENT OF THE BOARD OF  
MEDICAL EXAMINERS OF THE STATE OF NORTH CAROLINA,  
AND DELEGATE FOR NORTH CAROLINA TO THE AMERICAN  
CONFEDERATION OF RECIPROCATION AND EXAMINING  
LICENSING MEDICAL BOARDS.

Reciprocity between states as applied to the practice of medicine means an agreement between two state boards of examiners by which each will recognize the license granted by the other and grant to the holder of such license from one state the license to practice medicine in the other state without a second examination. For example, the Iowa board will recognize the license granted by the North Carolina board and grant a license to practice in the State of Iowa to an applicant holding a license from the North Carolina board without requiring the applicant to stand an examination before the Iowa board. This, upon the surface seems to be a very simple proposition, and much to be desired by doctors moving from one state to another, as only a very few of the best qualified doctors could pass these examination after they have been out in practice a few years, without first taking a special course of study to prepare themselves again upon the fundamental branches. At first we wonder why it has not long ago become common custom. When we investigate the question, we find it to be attended with many obstacles, complications and dangers, some of which are almost insurmountable.

If there were but a few states and all had for years maintained a somewhat uniform standard of requirement, and if all applicants were capable and honest, it would be an easy proposition. But we must remember that there are now in the United States 51 political divisions, and that the conditions and environments in these, many divisions differ widely, making very different standards of requirement necessary. The legislation in each has grown up somewhat spordically, many times more in conformity to the ideas of the laity and non-professional legislators, than to the ideas of medical men. Some states have a single board, in some there are mixed boards, in others two or three boards, our state having two boards at this time. In some the different sects are recognized in one way, in others in some other way. In some a high standard has been rigidly maintained for a

long time, in others for only a short while, and in yet others such a standard has not been attained. While the legislation of the several states has a general tendency upward and toward uniformity, it is more or less chaotic and unstable. Such being the general condition throughout the states, reciprocity should be embraced by North Carolina with a great deal of careful reserve and prudence.

Every state has absolute control of its own domain in all matters of police regulation, the practice of medicine being one of them. It has the right to fix the standard that it will require of its own citizens and other primarily licensed in the state. It also has the right to say whether or not it will recognize the license granted in another state or not, and if so, to fix the terms upon which it will grant such recognition. This power has generally been vested by the states in a board of health or a board of medical examiners.

The Board of Medical Examiners of North Carolina, having been created by act of the legislature of 1858-1859, is the oldest medical examining board that has been in continuous existence in any of the states. The medical profession of the state has always enjoyed great privileges and likewise great responsibilities. We control ourselves, and have been the authors of all important laws governing and promoting the practice of medicine in the state. The doctors have likewise been the authors of all important legislation of the state for the protection of the public health. While we have incidentally safeguarded the interests of the profession, we have always made the protection of the people and the public health of the state of first importance. The conditions and environments of the state being considered, our medical laws are about as good as we could wish for. We have also reached the time when our state boys, who are homogenous with the people, are not only supplying the needs of the state, but are crowding one another in the profession. We do not need to open a new and easy way of entrance into the profession in order to supplement the supply of doctors.

But, we are living in an age of progress, and must keep pace with the times. While we must safeguard with jealous care against the entrance of undesirable outsiders, we must not shut ourselves within a wall, refusing to recognize the better class of doctors who come to us from other states, thus creating the

impression that we are trying to maintain a monopoly, and working prejudice against our own licentiates, who will in the future be moved to other states in greater numbers than we receive in return.

This matter of reciprocity is with us and will not be brushed aside or smothered down, even if we desire to do so. In many of the states it is an established fact, and in common practice. As many as 50 reciprocal license per year have been granted by some of the states. It is in keeping with the greatly increased facilities for better and more general knowledge in regard to all sections of the country. Sentiment in favor of it is growing rapidly in all the states. There are at this time some five or six national organizations that come together annually and discuss it with a view to establishing a uniform standard of requirement and general reciprocity. There exists such a diversity of environment that it will be many years before such a uniform standard can be secured and maintained in all the states. But the work along this line has disseminated much knowledge, and has created such a wide-spread and popular demand upon us at this time as can scarcely be resisted.

The law which was enacted by our last legislature upon this subject was in obedience to this popular demand, and not desired by the profession in the state. In fact it was resisted by the profession upon the belief that the demand at that time was being made by a few undesirable persons, who hoped by means of reciprocity to evade our careful examinations and obtain an easy entrance to the profession in the state. In fact, there was no evidence at that time that there was a general desire on part of the people to open new and easy portals into the profession, and thus meet an demand for an increase in the supply of doctors for the state. However that may have been, we were in great danger of unconditional recognition of all license of the other states, without discrimination, being forced upon us by act of the legislature. Thanks and praise be to Dr. R. H. Lewis, of Raleigh, that this legislation was so directed as to leave the matter of reciprocity in the discretion of the State Board of Medical Examiners. We were very fortunate in having a wise and patriotic member of the profession in our capital city at that time, as in many other instances, to take care of our interests. If the effort to force unconditional recognition of the licenses of all



the other states upon us had been successful, North Carolina would soon have been flooded with the undesirable from all sections of the country.

Your Board of Examiners at its next meeting formulated a set of rules for reciprocity that would admit to the profession in this state those applicants from other states holding a license from states having a standard of requirement equal to our own. To have admitted those who had obtained a license for a state with a lower standard would obviously be discriminating against those who were offering to pass before our own board, against our own boys. This would be unjust, and would ultimately force our boys to go before the boards in other states with lower standards, and then come to North Carolina and demand that the license from the other states shall be recognized. As our standard is higher than that of all but two or three states we could only reciprocate in a very limited way. We can with safety say we will recognize the license of an applicant from another state, who upon examination made a grade as high or higher than our standard of requirement. This would enable us to reciprocate with most of the states; and would be greatly to the advantage of our licentiates who wish to remove to states having a lower standard than ours.

The matter of reciprocity or recognition of the license granted by another state board should always be put in the hands of the state licensing board. While there should be some conference and general agreement on part of our state board with the boards of other states as to reciprocity, it should be understood by both that it is to be reciprocity for the benefit of the *bona fide* doctors of each state of the desirable class, and not for the purpose of opening an easy avenue into the profession in either state of the undesirable class. We only want the better class who may come to us from other states, and not just any who may hold a license. On the other hand, we should be discreet in the class of men that we recommend to the other states for reciprocity. There are good and bad in the medical profession as well as in other avocations in all of the states. We should stand ready to receive the good, and at the same time discriminate against the incapable and the bad. It should always be kept in mind that the undesirable are apt to be the first to try to avail themselves of it. They will always be the most numerous and the most clamorous for it.

Our board should have a very complete and comprehensive form for the applicant to fill out upon making his application. Without this very important matters of requirement are apt to be lost sight of. No license obtained other than by examination should ever be recognized by our state. The photograph system for identification should be adopted and strictly adhered to; and all other safeguards against cheating and fraud employed. It would be well for the secretary of the board to be empowered to administer an oath to all applicants for examination as well as reciprocity to the effect that he is the person that he represents himself to be, that he is the rightful owner of the license and diploma which he holds and that he is not addicted to any drink or drug habit to the extent of impairing his usefulness as a practicing physician.

No state board should ever undertake to examine the recently graduated citizens of another state and recommend them for reciprocity; nor should any state ever allow its citizens who have recently graduated to obtain license before the board in a sister state and then come to the home state and demand recognition on the grounds of reciprocity. If one could go before the board in a sister state, pass the examinations and obtain a license that would entitle him to practice in the home state, there would soon be a scramble to get before the board that had a reputation for being easy to pass. There would be no chance for the preferment of charges against the man of bad character, for no one could know when or what board he would appear before. Substituting and other cheating could be carried on with less risk of detection. It would always be restricted to individual cases, and exercised upon a high plane. If properly conducted upon a high level of professional honor, dignity and courtesy it will be of great advantage to the worthy doctor who is moving from one state to another. It should be well understood that it is for his benefit, and for him only. It will not only save him great embarrassment, but also the expense, labor and time necessary to preparation for a second examination.

## SOME REMARKS ON AMOEBIC DYSENTERY.\*

BY GEO. M. NILES, M. D., ATLANTA, GA.

The synonym of amoebic dysentery—tropical dysentery—would lead some to suppose it of small interest to physicians in temperate latitudes; but, since our flag has been planted in the Philippines, giving rise to a constant stream of travel to and fro; in addition, the Panama canal, bringing thousands of our people, who labor there, into intimate touch with us; and also the large and growing fleet of fruit vessels, constantly plying between our shores and the South—and Central—American countries, afford such facilities for the introduction of this disease, that this subject may at any moment be of interest to communities far removed from the tropics.

The writer recently saw four cases in New York City, besides learning of some cases occurring as far north as Maine.

Amoebic dysentery, sometimes called intestinal amobiasis, is a colitis, latent, subacute, acute or chronic, caused by the amoeba coli.

Liver abscess is so common an accompaniment as to be almost considered one of the lesions. Gilman Thompson reports thirteen fatal cases, ten of which had abscesses of the liver.

It is prevalent in tropical countries, and to some extent in the extreme southern states. It is much more frequent in cities than is generally supposed.

The source of infection is chiefly contaminated water, green vegetables or fruit. Musgrave has found the amoeba on dishes washed in tap water, on the surface of uncooked vegetables, such as lettuce, in milk, and on the hands of attendants. Selli found them growing six feet below the surface of the soil near dysenteric stools, and also at an elevation of 5,000 feet.

The amoeba coli is about five times the size of a red blood cell, colorless, or with a pale greenish hue; has granular contents, a faint renders and active pseudopodia.

To obtain specimen for examination, flakes of mucus or pus should be selected; or the mucus could be obtained by passing a soft catheter, or through a rectal speculum. Preferably a saline cathartic should be given, as suggested by Musgrave, and the fluid portion of the stool examined. For satisfactory exam-

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\*Read before Fulton County Medical Society.

ination the bed-pan should be warmed, and brought to the laboratory immediately; or, if this is not practicable, the specimen should be kept warm until ready for examination, and then placed on a warm slide or stage. Several preparations should be made, and carefully looked over for the amoeba or amoeba-like bodies.

Generally they will be found in motion, and can be recognized. Swollen and altered epithelial cells must be distinguished from them. This parasite is sometimes found in great numbers; again only a few may be present. The number present seems to bear little relations to the severity of the attack.

Should there be a liver abscess, the amoeba will probably be found in the pus along with the leucocytes and broken-down liver cells, though this is not always the case.

*Pathology.*—There is oedematous swelling of the intestinal surface and infiltration of the submucosa, followed by ulcers, chiefly in the coecum and flexures of the colon and rectum. These ulcers have thickened irregular openings, but which are small in comparison to the destroyed tissue underneath the mucosa. As this sloughs away, extensive irregular ulcers may appear; or sometimes the ulcers are connected by fistulous channels. Sometimes when the disease has been in progress for a while, in the intestine may be seen ulcers in different stages, as well as cicatrices of those already headed. Occasionally the cicatrices contract, causing either irregularity in the surface of the mucosa, or strictures of the gut.

Should the amoeba reach the liver, abscesses follow, which may be either so small as to look like translucent dots; or larger, containing, besides amoebae, fat cells, degenerating liver cells and red blood corpuscles; or still larger, having thick hemorrhagic walls of liver tissue. Sometimes there are necrotic areas in the liver, unaccompanied by abscess. Occasionally this process extends, causing necrosis and liquefaction of tissue without inflammatory reaction developed by pus bacteria. This effect Thompson believes to be caused by toxins developed by them within the intestine.

*Symptoms.*—Amoebic dysentery usually begins with a moderate and painless diarrhoea, alternating with short and irregular periods of constipation. During this period of constipation the patient feels fairly well. There is usually a slight fever, but

seldom nausea or vomiting; while griping and tenesmus, if present at all, occurs only at the beginning of the disease.

The stools are at first copious, watery of a grayish color and, later on, mucous and bloody. They vary in number, sometimes running as high as forty in twenty-four hours. The patient becomes emaciated and anaemic from the constant drain both of blood and albumen. The stools vary in appearance from day to day, but are all times fluid in consistency, and extremely offensive. Some cases described by H. A. West lasted for weeks without blood in the stools. In other cases symptoms of hepatic abscess with fever preceded the bowels manifestations.

The course of the disease generally runs through two or more months, followed by slow irregular convalescence. Relapses are frequent, arising upon the slightest indiscretion.

Prophylaxis is very important. All drinking water should be boiled, and dishes should be washed in boiled water, also the hands. Raw fruits or vegetables should first be put on ice, and then have boiling water poured over them. This will kill the amoeba. The vaginal douche or rectal enema from suspected water should be avoided. It is also important to sterilize the stools. This may be safely accomplished with carbolic acid 1 to 1,000. The same precautions should be observed with soiled linen.

*Treatment.*—In the acute form the patient should be put to bed, and on liquid diet, as barley-water, bouillon, broths, gruels, white of raw eggs, or peptonized milk diluted one half with either lime or barley-water. Either Sanatogen or Somatose will be found helpful, and are generally well borne. For the pain or colic in the abdomen use hot stupes, poultices, or hot-water bag.

*Internal Medication.*—Both Musgrave and Kemp object to bismuth preparations, in that they coat over the ulcers, thus interfering with local treatment. A possible exception to this is the subgallate of bismuth. In the initial stage cleanse the intestinal tract with sulphate of magnesia or castor oil. Some use calomel, but the writer is not much in favor of it in this stage of the disease. Neither has the writer gotten satisfactory results from the combination of salol guaiacol and ipecac so highly thought of by some observers. Strong reports some benefit from acetozone 1 to 5,000, or 1 to 3,000 in carbonated water in-

ternally, 1 to 2 litres in twenty-four hours, in divided doses. Other valuable remedies are salicylate of guaiacol grs. v to x, given three or four times daily; tannalbin, grs. x; tannigen grs. x; tannigenaform grs v to x. Dilute hydrochloric acid with pepsin, or alone, is of value, for often the secretions of the stomach are in abeyance. Vomiting should be treated as that arising from any other gastric irritation.

Local treatment is very important for the acute, latent and chronic forms. The following are destructive to the amoeba as well as to other bacilli.

Acetozone 1 to 1,000. Most so.

Alphozone 1 to 1,000. Nearly as much.

Argyrol or protargol 1 to 500.

Bisulphate of quinine 1 to 500.

Thymol 1 to 2,500. Very good.

Permanganate of potash 1 to 2,000.

Peroxide of hydrogen 5 to 10 per cent.

Tuttle recommends cold water (45 F.) given in knee-chest position, and contained half an hour.

*Method of Irrigation.*—A glass irrigator with a colon tube with an opening preferably at the end should be used. If the ulcers are low down in the rectum, or there is extreme tenesmus, the physician may use an ordinary rectal tip.

When administering the irrigation, the foot of the bed should be elevated 12 to 18 inches, and the patient placed in Sims position, or with his hips elevated on the pan. As the irrigation proceeds, his position should be changed so the fluid will tend to gravitate into the caput coli. This is admirably described in Kemp's book on enteroclysis and hypodermoclysis. At least one to two litres should be injected, and should be retained 5 to 15 minutes—the longer the better. A smaller quantity may be used at the start, should much irritation be present.

The knee-elbow position may be used in chronic or latent cases, but will hardly prove feasible in the acute. Should the irrigation cause excessive pain, it may be preceded (half hour) by two ounces normal salt solution containing morphine 1-4th gr. and belladonna 10 drops. This should be done only once or twice in the first twenty-four hours of the treatment, and not repeated, if possible to avoid it.

Kemp sometimes uses acetozone 1 to 5,000 combined with

quinine 1 to 750, giving two to five enemas in twenty-four hours, according to the severity of the case. Should cold injections be badly borne, hot (120 F.) may be used instead. And should any of these preparations disagree, the list is broad enough to allow discretionary changes.

In latent cases bowels should be opened freely, and daily injections of quinine and acetozone given. Should large or small injection fail to be retained, recurrent irrigation (preferably with the Kemp tube) should be employed. One or two gallons of half-strength solution may be used, with the foot of the bed considerably elevated. The tannic acid preparations suggested in acute cases, are admissible; also the same injections, but not so often.

Change of climate is frequently of much benefit.

High fever should be controlled by sponging, antipyretics not being often indicated. For weak heart strychnine or spartein may be used, as in cardiac weakness from any other cause.

Experiments are being made as to the efficacy of giving 1-4 gr. of fluorescin in 6 ozs. of water, and placing the patient in full electric light. This promises well in latent or chronic cases, but can hardly, as yet be intelligently reported on.

The writer wishes to make acknowledgements to Messrs. Musgrave, Strong, Gilmore Thompson, Boardman Reed, and especially to Dr. Robert Coleman Kemp, of New York, in whose gastrointestinal service at Ward's Island and West Side German Dispensary, he was afforded facilities for studying this interesting and important disease.

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## THE IMPORTANCE OF A THOROUGH KNOWLEDGE OF BIOLOGY, BACTERIOLOGY AND THE CIRCULATION OF THE BLOOD FOR THE SUCCESSFUL APPLICATION OF SERUM THERAPY.\*

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BY J. C. GRADY, M. D., KENLY, N. C.

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The subject I have selected for my paper is supposedly a physiological one: "The Study of the Circulation of the Blood Biology and Bacteriology and Their Relation to Serum Therapy."

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\* Read before Medical Society, N. C., June 15, 1908.

But should I digress somewhat from the letter of my text, I beg your pardon and kind indulgence in advance, while I attempt to rehash this old threadbare subject that circulation of the blood is so inseparably connected with bacteriology and serum therapy. I do not expect to be able to advance any new ideas along these lines; but if I can succeed in provoking a discussion of the subject, then the object of my paper will be attained.

The uses of the circulating blood may be summarized thus: It is a medium for the reception and storing of matter, that is, oxygen and digested food materials from the outer world for conveyance to all parts of the body. It is also a source from which all the various tissues of the body may take the materials necessary for their nutrition and maintainance, and whence the secreting organs obtain the constituents of their various secretions.

It is also a medium for the absorption of deleterious or refuse matters from the various tissues and their conveyance to the eliminating organs for their expulsion lest the system become, by auto intoxication, her own destroyer.

It seems to me that a thorough and concise knowledge of the chemical constituents, biological elements, physiological and opsonic functions of the blood together with its course and manner of travel over the system is absolutely indispensable and merits our most thorough and painstaking study, if we would elucidate the mysteries and solve the problem of serum therapy and understand the important role the circulation plays in physiological and pathological processes. As you know, for the last few years there has been a great tidal wave of chemical and bacteriological research sweeping over this country and Europe. The human blood has been subjected to an endless variety of the most critical and searching tests, and this bacteriological crusade has put scientists and medical men everywhere, on the alert hunting for a more satisfactory aetiology and a more dependable treatment for the ills that afflict humanity. Medical and scientific men have been standing with microscope and chemical retort in hand striving to recognize and capture the baneful micro-organisms or materies morbi that foster disease and engender death, and while as yet the goal has not been attained, many new and startling truths have been evolved, many false and erroneous theories exploded, and many valuable improvements added to our



rapidly increasing knowledge of bacteriology and serum therapy. Many of these innovations and improvements are things too that **only a short while go would have been considered unreasonable and visionary in the extreme if not downright medical heresies.** Conspicuous among these may be mentioned Wrights opsonic theory of injecting into the blood certain specific bacterins or serums that will so stimulate phagocytosis or the opsonic power of the white blood cells that they will become little corpuscular cannibals that will destroy and drive out every disease germ in sight and render the system absolutely sterile and immune against them.

So you see how essential it has become in these days of change and rapid scientific thought and discovery that physicians should keep themselves thoroughly informed on all physiological and biological subjects and especially those that pertain to the circulation of the blood, bacteriology, and its most powerful ally, serum therapy. The blood being the principal medium through which and into which the various bacteria toxines and other poisons must enter the system and find lodgment preparatory to begining their nefarious work of tissue poisoning and destruction, we should endeavor to learn some plan of preventing their entrance, of combatting their presence and off-setting their methods of proliferation.

We need to study their individual characteristics and learn their haunts and habits that we may be able with out antitoxins and blood serums to break into their strongholds, tear down their fortifications, and drive them from their entrenchments in the system; and at some time in the near future we expect to be able to do this in almost every case of germ infection by the application of appropriate bacterial serum just as we now do by inoculation with vaccine virus to destroy or counteract that certain pabulum, toxine or what not in the blood that feeds the germ of small pox. Now you would hardly expect a man to recognize a pathological condition in contra-distinction to a physiological one, if he were unfamiliar with the physiological. In order to understand and fully comprehend serum therapy one must familiarize himself with the different influences and agencies that conspire to bring about its peculiar manner of action. The importance of physicians keeping themselves at all times thoroughly informed on the circulation of the blood and its normal physiological func-

tions together with a corresponding knowledge of bacteriology and pathology as an aid to a correct understanding of disease and the application of the serum treatment becomes evident.

Now, inasmuch as the food after digestion becomes absorbed by the lacteals and lymphatics and is carried by the portal or lesser circulation directly to the liver, the blood to that extent becomes an accessory of the digestive process for the ultimate purpose of nutrition and tissue building, which process is accomplished by the food elements being conveyed to the different parts of the body and tissues by the circulating blood current. Here we see what an important part the circulation plays as a carrier and the power it has any may exercise in the inoculation and spread of disease germs throughout the human system. Should they enter the system by the stomach, they are carried by the portal circulation to the liver and systemic circulation through which not only materials for repair are conveyed, but disease germs or curative agents as well, by being taken up by ingestion and absorption along with the food and carried through the portal circulation to the systemic circulation and tissues at large.

So we see while the portal circulation is primarily a carrier of nutrition, it may also become the purveyor of deadly disease germs or be utilized for the better purpose of conveying curative agents in the form of antitoxins. It is this phase of the circulation that we wish to study and strive to better understand and learn to more frequently utilize as a carrier of antitoxins and medicaments to the diseased tissues which in combination with the ingested and digested food elements are transported directly to the liver. Leaving the liver, it then goes to the right side of the heart with its normal constituents and toxins or antitoxins, thence to the lungs performing again the same office and in addition given off some of its poisonous gases for oxygen. Thence, it goes to the left side of the heart where together with its death-dealing toxins or its life-giving nutriment and medicaments, it is poured into the general systemic or arterial circulation either to poison or to purify the whole life giving stream. So you can easily see how bacteria and disease germs and their antagonistic serums, whether entering through peripheral lesions or by ingestion and absorption, can be rapidly assimilated by the simple and normal process of the circulation of the blood, and how poisonous germs or medicaments that may enter or

become injected into the circulating fluid, either from within or without may easily gain access to the cells and tissues of the entire body.

Oftimes, the tissues and cells of the body becomes so weakened and overpowered by toxins and disease germs that nature's unassisted forces are unable to properly police the system until her diminished and impaired opsonins are replenished and rendered adequate to the task of driving out these hordes of invading microbes that have entered it and caused nature's powers to be overthrown and the energy of her immunizing and opsonic forces to be lost; then it is that we may be able by an intelligent understanding of the blood and circulatory apparatus and the vulnerable points of microbic life, by the use of hypodermic or intra-venous medications and those which can be administered by ingestion reach and counteract or neutralize these invading toxins, ptomaines, and other poisons before they become fully established in the system.

For as we have already seen, medicaments as well as poisonous germs can be rapidly taken up by absorption from the digestive tract and passed along with the ingested and digested food to the portal circulation, and thence to the general circulation of the entire body either to the restoration and preservation of its health-giving functions or to the poisoning of the tissues and the destruction of vital processes. So you can readily see how the germs of anthrax, syphilis, tuberculosis, typhoid fever, pneumonia and all that horde of disease germs, after gaining entrance to the circulation, may rapidly disseminate themselves throughout the body.

Now when we remember that the blood makes a complete circuit of the whole body every twenty to thirty seconds, then we can begin to appreciate to some extent the danger and power of the blood current as a germ carrier and also obtain some idea of its importance as a disseminator of curative serums, when injected into its current to stimulate its opsonic forces to resist disease and keep our bodies to the standard of health. This process will be accomplished in direct ratio to the opsonic index of the blood cells and in proportion as the tissues receive and contain a normal and sufficient supply of healthy blood in every part of her vessels or circulatory apparatus.

In this way, the requirements for the health of the organism

will be met and the whole scheme of life and health will resolve itself into the one condition, that we keep the circulation of the blood throughout the different parts of the body continually active and the opsonins in the blood up to the normal standard of their working capacity. Whereas, should we fail to do this, the circulation will at once become impaired and sluggish, its vital functions altered, its opsonic powers diminished and inefficient to the dangerous extent that we must immediately multiply physiologically, artificially, or otherwise. These deficient opsonins may be increased by the injection of appropriate bacterial serum and in suitable quantities, restore to nature her lost physiological balance, and enable her to drive out and resist invading organisms.

Ever since the day Mayerhofer isolated the streptococcus pyogenes from the blood of a dead puerperal woman, and Pasteur produced living cultures of the same and demonstrated it to be the principal cause of puerperal sepsis, it has been the dream of the profession to produce a serum with which the poisoned system woman's blood could be reached in some way either by direct injections or by ingestion and absorption through the stomach. I believe that Mulford & Co., and other makers of antitoxins and bacterins are experimenting in the right direction. And who knows ere another decade shall pass but that we shall make even greater conquests over this terrible scourge with blood serums and bacterins than we have in the past with cleanliness and antiseptics until the horrors of the puerperal state shall become a byword of the past?

I believe that right along this line of serum therapy, we have the richest unexplored field of medical science. It devolves upon us as physicians to develop it to the end that we must familiarize ourselves with and take advantage of every agency and circumstance that bears upon it; or that will in any wise aid us in our undertaking. Whether it be the circulation of the blood, chemistry, bacteriology, pathology, or any other closely allied subject, we want to study the hematolytic, as well as the antitoxic action of bacterial cultures on the human blood, since there is unquestionably a significant relation between them not yet thoroughly understood. We want to obtain a more definite knowledge of the powers and functions of the antibodies found in blood serum and get a better working knowledge of the germici-

dal properties of the normal circulating blood in order that we may gain a clearer insight in to the combining and resisting powers of healthy human serum.

We have already learned that there is great variation in the capacity of different normal systems for appropriating and assimilating immunity-giving serum. And we would also like to understand the manner by which the babe appropriates the mother's immune bodies in the milk and why it is that nature-furnished nutriment is supplanted and artificially prepared food substituted, so many infants wither and die like tender grass before a killing frost. By the acquisition of just this one item of knowledge we may be enabled to wonderfully lower the high mortality rate among bottled-fed infants. We want to look in at the open door that leads to a knowledge and explanation of the normal activity that controls cell multiplication and the process which occurs in the circulating blood called autolysis or self digestion of inflammatory exudates, and understand how the production of these agents or ferments are brought about and controlled by the system. In short, we want to study the circulation of the blood in all of its relations to serum therapy, and serum therapy in all its relation to the circulating blood, because the two are so closely related, interwoven, and interdependent that, to understand the one, we must necessarily understand the other. And the acquisition of a comprehensive knowledge of both will wonderfully aid us in grasping the thousand and one intricate and puzzling clinical phenomena connected with the blood and serum therapy.

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#### A REPORT OF CASES TREATED WITH ICHTHYO- LATED EMULSION COMPOUND.

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BY JOHN ROY WILLIAMS, M. D., GREENSBORO, N. C.

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Ichthyol, as a valuable adjunct in the treatment of tuberculosis, has been recognized for over twenty years. It has not been used as largely however, because of its disagreeable odor and taste. Heretofore it has been prescribed in aqueous solution, in capsules or as the gelatin-coated pills.

It is a recognized clinical fact that Ichthyol improves the di-

gestion and assimilation, with little or no irritation of the gastro-intestinal mucous membrane if carefully applied. It lessens tissue destruction, especially the albumens, as shown by diminished nitrogenous excretion; it increases the flesh and strength by increasing the appetite, digestion and assimilation, thereby lessening the outgo and increasing the income. It is eliminated chiefly by the kidneys, in the form of sulphur compounds, acting as a diuretic. It contracts the capillaries, improving the general circulation tends to rapidly convert a purulent sputum into a mucoid sputum, making it more fluid and easily raised, improving the drainage from the diseased foci and lessening the absorption, which is the chief cause of rapid heart and fever. It often rapidly re-establishes the menstruation in tubercular anæmic women, and the night-sweats in most cases soon stop. It improves the nutrition of the heart throughout its constricting action on the coronary arterioles, and indirectly, through its several physiological actions, lessens blood destruction and assists in building up the same.

1.—Potter says, "the particular value of ichthyol is due to its non-irritant quality and the large proportion of sulphur contained therein. It retards the disintegration of albumens and favors their formation and accumulation."

2.—Bartholow says, "It increases assimilation and hinders retrograde metamorphosis, whereby the nutrition is improved and the body weight is brought up to the normal level. Has a decided antiseptic action and is fatal to pathogenic organisms. It increases the volume and force of the circulation. Has a remarkable power to check waste, the urinary solids and nitrogenous excreta being greatly diminished. Hence under its administration, the body weight increases, the income is promoted and the outgo is lessened, and these important results are accomplished without in any way impairing digestion or irritating the gastro-intestinal mucous membrane."

3.—Cohn says, "it increases the strength of the organism and places itself in a favorable position to carry on a successful warfare against the bacilli of tuberculosis. In advanced cases improvement often follows when Cod Liver Oil and Creosote have failed."

4.—Branthomme says, "he considers the action of ichthyol similar to creosote, but without the disadvantages of the latter."

It is less irritating to the stomach than creosote, diminishes expectoration, causes an increase in weight, improves the general condition of the patient, and restores menstruation in tubercular anaemic women."

5.—Combemale and Desoil report that, "during fourteen months all tubercular patients at the Charite Hospital at Lilly were treated with ichthyol. There was prompt improvement in the general health of the patients, as manifested by the disappearance of the night-sweats, gain in weight and strength, and a re-appearance of the menses. The expectoration is almost invariably lessened in amount and made more fluid, so that coughing is easier."

6.—Stubbert reports that, "of all drugs used in the Loomis Sanitarium at Liberty, N. Y., for phythisis, ichthyol had yielded the best results. Under its influence the sputum was more easily brought up, because less yellow and more of a mucoid appearance. There was amelioration of chills, sweats and fever."

7.—Williams says, "he has used ichthyol in several hundred cases of pulmonary tuberculosis, with good results in a large majority of cases. He has found the appetite and digestive powers increased, the daily average of temperature lowered and the sweats in most cases to cease. The bacilli rapidly show degenerative changes, with a gradual disappearance of them from the sputum. The cough is modified, the expectoration becoming easier, the sputum becoming more fluid, losing its purulent character, and gradually decreasing in amount."

The odor and taste of ichthyol have for the past twenty years, prevented many consumptives from having the advantages of this remedy. Prescribed in aqueous solution, it is foul tasting and odorous, very often nauseating to a degree to produce vomiting. The very large dose, which sometimes becomes necessary to obtain its benefits, has added to these disagreeable features. Given in capsule, the odor and taste have not always been eliminated; also some patients have found it very disagreeable or impossible to swallow the capsule, due, however, to a neurotic cause, yet nevertheless existant. It was also difficult to get the patients to take enough water with each dose to make a dilute solution in the stomach, so as to prevent irritation, with consequent eructation or "rifting." Since the gelatin-coated pill often passes out with the stool, being undissolved in the stomach or bowel,

the therapeutic action of ichthyol in this form can not be depended upon.

For the past several months, I have been using ichthyol in the form of ichthyolated emulsion compound. It contains ichthyol, grs. x, apinol, min. x, ol. sassafras, min. v, ol. olivae, ol. gossypii seminis, glycerinum and mucil, acacae, qs oz. i. The odor and taste of the ichthyol are disguised. The apinol incorporated, which has all of the physiological actions of creosote, with much less tendency to irritation, enhances the action of the ichthyol and eliminates the necessity of such large doses.

I find that this emulsion gives all the physiological effects of ichthyol and creosote. That it is well borne by the stomach and bowel, has a tendency to overcome constipation, is almost a specific for indicanuria. I give it in a glass of cold milk, six times daily, beginning with a teaspoonful at a dose, slowly increasing until the patient is taking a tablespoonful at each dose.

I have seven cases which I have treated with this emulsion, I wish to report in a general way. Four of them were first stage cases, all having slight fever and accelerated pulse. Three of these cases were complicated with a tendency to constipation. The average length of time treated was nine weeks, and the average gain in flesh was 19 pounds. The highest gain was 26 pounds, the lowest was 12 pounds. All were having a normal pulse and temperature, and the cough and expectoration had disappeared at the expiration of treatment. There seemed to be an arrest or cure of the disease in each instance.

There was one second stage case, a rather large woman, weighing 144 pounds when beginning treatment. Her temperature was 101.5, pulse 114. After eleven weeks' treatment she had gained 23 pounds, the temperature and pulse being normal, and the cough and expectoration had almost entirely ceased. She stopped treatment and has been lost sight of. She gave promise of making a complete arrest or cure of the disease.

The remaining two cases, were third stage cases, one complicated with tubercular laryngitis, the other with tubercular enteritis. Both had both upper lobes involved, and were having high temperature and rapid pulse. The cases complicated with tubercular laryngitis, was treated for fourteen weeks, with considerable improvement in the lung condition, no change in the larynx, with prompt reduction in temperature and slower heart



action, gained must in strength and added 8 pounds in weight. He stopped treatment, went home, and has since grown worse. The other third stage case, complicated with tuberculosis enteritis, made a far greater improvement. The bowel condition was apparently arrested by the use of magnesium sulphate, in five grain doses every two hours for three weeks. The lung condition greatly cleared, becoming quiescent, and the patient gained 26 pounds in seventeen weeks. Her temperature and pulse reached the normal. She went home, from where she reports she is doing as well as when she left my care.

I employed in all these cases, the usual hygienic and dietetic treatment, and with the two third stage cases, and one of the first stage cases, I employed tuberculin. While I have use ichthyol in capsules in my practice in a large number of cases, the results I have obtained with ichthyol in the form of an emulsion, have been far superior. While ichthyolated emulsion compound has not produced these good results unaided, yet I feel and believe that it has been a most valuable adjunct.

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### SERUM THERAPY IN TUBERCULOSIS.

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BY DR. LOUIS C. ROUGLIN, EX-VICE PRESIDENT AMERICAN ANTI-TUBERCULOSIS LEAGUE, SECRETARY GEORGIA ANTI-TUBERCULOSIS LEAGUE, MEMBER AMERICAN MEDICAL ASSOCIATION, SECRETARY SOUTHERN SANITARIUM ASSOCIATION, PHYSICIAN TO PINE RIDGE SANITARIUM FOR TUBERCULOSIS, ETC., ATLANTA, GA.

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*Synopsis of Subjects.*—Tuberculin vs. Drug Therapy—Method of Preparations—Mode of Action—Report of Cases—Method of Administration—Conclusion.

Science has demonstrated two facts, which are of supreme

importance to the millions of people who live in daily dread of "The Great White Plague." These facts are:

First—That tuberculosis is a preventable disease.

Second—That of all grave diseases, pulmonary tuberculosis, in its incipency, is the most easily cured.

Drug therapy, however, having no influence on the bacillus, has proven an absolute failure, and in most cases has done more harm than good. The powers of digestion, assimilation and nutrition is the stronghold of the consumptive. Derange these factors and the patient is lost. What, therefore, can be more injurious than the indiscriminate drugging of the consumptive with mercury, arsenic, creosote, guaiacol, cough-syrups and the like, when instead of improving the appetite, in the bulk of cases it destroys what little appetite the patient had. **RUIN HIS DIGESTION, AND THE PATIENT IS DOOMED.**

Hygienic and dietetic care does all the good that can be desired for the general condition, and for the specific tubercule, Serum Therapy, offers the only hopeful, reliable and efficient solution for the condition.

*Methods of Preparation.*—As a prelude, I believe it to be of interest to review briefly the various steps made in the methods of the different preparations of tuberculin, given in detail, such preparations only, that are most commonly used, and briefly showing the progress made in its preparation from the time of its discovery by Koch in 1890 to the present date.

Tuberculin Old as prepared originally by Koch is as follows: Transfer Tubercule bacilli from a pure culture into a flask containing sterile glycerine bouillon (beef extract 1 per cent., pepton 1 per cent., glycerine 5 per cent.) and allow to grow from 6 to 8 weeks. Concentrate the contents of the flask by boiling to one-tenth its original bulk and filter. The filtrate represents ten per cent. extract, ten per cent. peptons and fifty per cent. glycerine in water.

In 1891, Hunter, of London, removed the beef extract, peptons and glycerine by precipitating the tuberculin with platinum chloride, which carries down albumoses and peptons and used the filtrate.

In 1893, Klebs precipitated Koch's tuberculin with sodic iodide of bismuth, then further precipitating the filtrate with ab-

soluble alcohol, collecting the residue and re-dissolving in water, obtaining one per cent. organic substance in solution.

In 1894, Klebs used only the filtered glycerine bouillon, upon which the tubercle bacilli had been grown, avoiding boiling heat.

In 1896, Von Ruck boiled in a vacuum the whole culture (tubercle bacilli and glycerine bouillon) from 4 to 6 weeks at 130 degrees F., with the exception of extracting more toxins from the germ. Objections raised to these various methods are: Heat used that is likely to injure the toxins, the uncertainty of the amount of toxins, the presence of the glycerine, beef extract and bouillon, which is very irritating hyperdermically.

Koch's New Tuberculin T. R. was announced by Koch in April, 1897, and is prepared from bacilli of a virulent culture, dried in a vacuum in the dark and pulverized. The powder is then put in distilled water and centrifuged at a high speed for about forty-five minutes. The upper clear liquid consisting of fat and debris is decanted and discarded. The precipitate is again dried in a vacuum in the dark, again suspended in water, and centrifuged, and the residue is again treated as before. This process is repeated several times, and the residue finally obtained is known as Tuberculin Ruckstande or T. R.

In May, 1897, Von Ruck announced a preparation from the bodies of Tubercle bacilli, which are first washed, then dried and powdered. The fat is then extracted with alcohol and ether. The residue is then dried and powdered again and finally extracted in distilled water.

More recently Koch prepared an emulsion which consists of a suspension of ground up Tubercle bacillin 50 per cent. glycerine so that each c. c. contains 5 mg. of the powder.

*Objections.*—In all the latter preparations the objection to heat is eliminated. The possibility of infecting the patient with a virulent bacillus is considered as a disadvantage. This, however, is guarded against by careful bacteriological examination, or by heating to 60 degrees C. for two hours.

*Mode of Action.*—Tuberculin when injected beneath the skin excites an inflammatory reaction, which manifests itself by fever, malaise, nausea and even vomiting, while locally, we get Rales. If the dose be too large, or, regardless of reaction if the injections are continued, necrosis of the tubercular areas, cavity formation and increased infiltration at the periphery occurs, but

when administered in very small doses and increased cautiously so as to avoid febrile reactions, it is asserted that the local inflammatory changes lead to formation of fibrous tissue, which shuts off the Tuberculosis foci. Dr. Julien Citron explains the action of Tuberculin as follows: The Tubercule bacilli or a portion of their body substance, in an unknown manner, unite with the receptors of the bordering cells; the cell receptors so attacked are over-compensated by the cell, and as a result we may distinguish four stages.

**First Stage**—An increase of the receptors (antibodies) attached to the cell.

**Second Stage**—Increase of the attached receptors and the presence of free antibodies in the foci of infection.

**Third Stage**—A great number of attached receptors with a diminution of the free antibodies. In all three stages there exists a specific hypersensibility to tuberculin. When tuberculin is introduced in small amounts into the organism, there is no reaction by the normal cells, but the cells provided with receptors for tuberculin in and around the foci of infection, are attacked and combine with tuberculin, producing the reaction which is characterized by fever and other symptoms. The cells so attacked immediately produce great numbers of receptors (antibodies) to compensate for those attached by tuberculin. There occurs under the influence of tubercule bacillus preparations (tuberculins) a new formation of agglutinins, anti-tuberculin and opsonins.

**Fourth Stage**—After long continued injections of small amounts of tuberculin, anti-tuberculin is found in the serum, and this brings us to the fourth stage in which there are many fixed receptors, and also a large number of free antibodies at the point of local infection and in the serum. To reach this stage tuberculin must be injected over a considerable length of time, and in sufficient quantities to stimulate the cells to the production of anti-tuberculin and not to the point of intolerance or toxic-effects.

**Report of Cases.**—From a series of 39 cases of Tuberculosis which have been under my observation and treatment during the past three years, the following selected cases will serve as an illustration as to the progress made under the administration of tuberculin. Of this series 19 are completely cured six months or more, eleven have made marked improvement and are not now

under treatment. Eight are improved and are now continuing treatment, one died during treatment with acute pneumonia. In this series are not included cases which were seen too late, and when the use of serum was not advisable.

Case 1—G. W., male, age 28, was advised by a New York physician to go South on account of his lungs. Gave a history of night sweats, rapid loss of weight, and several small hemorrhages from the lungs. Tubercle bacilli found in the sputum by New York Board of Health. Patient coughed incessantly, runs an evening temperature of 101 degrees to 101.5 degrees F., weighs 127 pounds, physical sign were those of marked consolidation of upper right lobe, and to a lesser degree at the upper and lower lobe of left side. Injections of tuberculin began on 14th day after first examination, and continued for 22 weeks, cough and fever disappeared entirely, and repeated examinations of the sputum fail to reveal any T. B. and all abnormal signs of chest have completely cleared up. Patient now weighs 157 pounds, and is actively engaged in the mercantile business in Atlanta.

Case 2—Mrs. W. T. C., referred to me by Dr. George Brown, age 32, gave history of three successive attacks of pneumonia, had grippe four months ago, continued coughing and lost 18 pounds. Had several small hemorrhages from the lungs; evening temperature ran as high as 103 degrees F. Tubercle bacilli present in the sputum. Physical examination revealed diseased condition of practically over the whole of both lobes of left side, and pleurisy on both sides. Tuberculin began six weeks after first seen, cough and night sweats disappeared after fifth week of injections, appetite improved and patient gained in weight. Treatment continued for 8 months. Patient feels absolutely well. T. B. are yet found in the sputum in small numbers, and some of the physical signs are still present. When last seen, more than eight months after last treatment, patient claimed to feel perfectly well, and on that account refused further treatment.

Case 3—I. S. male, age 42, had pleurisy on right side a year ago, was confined to bed three weeks, was never relieved entirely of the pain, had to go to bed again six months ago for two weeks, and has been coughing and felt sick ever since. Cough worse at night and early morning. Had four severe hemorrhages from the lungs, has night sweats and feels very weak and lost

some flesh. Sputum did not show any T. B. On consultation with Dr. Todd, patient went to Asheville, but returned in six weeks with all the symptoms aggravated. Physical signs showed evidence of marked consolidation of upper right lobe and numerous Tubercle bacilli were now found in his sputum. Treatment continued for five and a half month, and now, over two years since his last injection patient holds his usual weight, is attending to his duties as manager for a department store, and shows absolutely no evidence of the disease.

Case 4—J. R. male, age 19, referred to me by Dr. George Brown, gave history of eight months rapidly failing in health, night sweats, expectoration and troublesome cough. Lost 18 pounds in weight, hoarse, pulse 120, temperature 102. Appetite poor, complains of heart burn, indigestion, and occasional vomiting, of food. Physical examination shows involvement of both apices, that of the right being more extensive. Patient was under treatment for 12 months, and while at first he seemed to decline, later, however, he made steady progress and finally improvement became rapid. He is now conductor on the street cars of Atlanta, and when last seen looked robust, and has grown rather stout, and says he has not had the slightest sign of illness in the last 12 months.

*Method of Administration.*—Under no circumstances do I institute any form of treatment until I have the patient under complete observation for at least 24 hours, having his temperature, pulse and respiration taken and recorded every three hours. Also the condition of his bowels, kidneys, etc., properly observed. I then prescribe such measures as the condition may indicate, laxatives or purgatives as the case may demand. No drugs for the cough unless same is very troublesome. Cold sponging for the night sweats, or a sponge with alum water. Drugs only when these fail and the sweats are excessive and severe. For the temperature, my rule is, that whenever my patient shows a rise of temperature, of, even as low as one-half a degree, he must rest, and rest in bed. As to diet, I give my patients food at frequent intervals. Food such as is found by observation in each individual case, that the patient can best digest and assimilate, raw eggs, milk, cream. Keffir in such quantities as can best be borne by the patient.

The injections of tuberculin is not given until the patient has been free from abnormal temperature for 24 hours, this rule is

absolute, and one to which I have so far made no exceptions. I begin the initial dose with 1-1000 gm. and increase the dose gradually and cautiously until my patient gets 1-4 gm. without producing any reaction. Under no circumstances do I give another injection until all local and constitutional signs of the reaction, if any, have disappeared. Under no circumstances do I increase a dose, if a lesser dose shows any signs of producing a reaction. Under no circumstances do I give an injection if the patients' condition is below his usual standard from any cause.

Slight digestive disturbances, headaches, malaise calls for an interval of rest from injections, and the next injection is not given until all those minor symptoms have been overcome. By following this method we may produce tuberculin immunity in a patient without causing marked reaction or any disturbance of the patient's general health.

The use of the opsonic index as a control for serum therapy in tuberculosis has many advocates, while a good number of competent observers do not consider it necessary or advisable. So far I cannot speak from personal experience on the subject, but at the Pine Ridge Sanitarium, where I have the advantage of making careful and accurate observations, I am now having taken and recorded, the opsonic index of every patient treated, and as soon as a sufficient number of observations have been made, over a suitable length of time, I shall give a report to the Society of the results of the opsonic index in relation to tuberculosis as observed at the Pine Ridge Sanitarium.

*Conclusion.*—In conclusion I wish to state my belief that in tuberculin we possess a remedy for tuberculosis, which may be justly considered a specific, at least in the earlier stages of the disease, and the adverse reports, made by earlier observers, were due to faulty methods, of administration, and an improper conception of its use. When properly employed, one is forced to admit that in tuberculin, we at least possess a remedy which is far superior and accomplishes more good than any other drug known. But in order to obtain the best results from its use, it must be given by competent men, and should be combined with proper hygienic and dietetic treatment. We also must not forget that it is a remedy which possesses great dangers, as well as great virtues—that the utmost amount of care and caution is necessary to obtain the best results, and that in the hands of the careless and inexperienced it may bring ruin and disaster.

829-30 Candler Building, Atlanta, Ga.

# EDITORIALS

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## THE INTERNATIONAL CONGRESS ON TUBERCULOSIS

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The Sixth International Congress on Tuberculosis, which met in Washington, D. C., from September 28th to October 3rd, was a marked success, of which every American, and especially the members of the medical profession may justly feel proud. It was a success in every way, from attendance and scientific papers to the weather and entertainments. The exhibits were the best ever presented to the public, of great variety, interesting and instructive, and of much educational value, both to the profession and laity. They opened September 21, and continued until October 12th.

The section meeting which was really the congress, began with a general meeting September 28th, and closed with another general meeting October 3rd.

Over these general meetings, Secretary Cortelyou presided as the special representative of President Roosevelt. At each of these meetings, Dr. John S. Fulton, the secretary general, called the roster of the nations and over a score of foreign governments responded through their official representatives. The oldest and the youngest nations were there, China and Panama. The largest and smallest, Russia and Belgium, thus manifesting the world wide interest taken in the study of the Great White Plague. Every state in the union was also represented by delegations varying in size from three to a hundred. Georgia had about a dozen present.



One could not fail to be impressed with the linguistic accomplishments of the foreign physicians, for while French, German and Spanish were the official languages of the Congress, as well as English, nearly all spoke the latter accurately and fluently. This was particularly noticable with the Japs and Chinese.

At the last general session President Roosevelt made a splendid address to the congress in which he gave an appreciative review of the noble work done by the medical profession in stamping out disease, and alluded especially to what had been accomplished by the president of the American Medical Association, Col. Gorgas, in Panama.

Prof. Robert Koch was there, of course, for a Tuberculosis Congress without Koch, would be like the play of Hamlet with Hamlet left out. Naturally he was the cynosure of all eyes when he appeared, but his pet theory on the non-transmissibility of bovine tuberculosis to man received a pretty severe jolt.

At a joint meeting of sections 1 and 7, (Pathology and Bacteriology and Tuberculosis in Animals) Prof. Koch reiterated the statement made at the London Congress in 1905, but Prof. Woodhead, of Cambridge, England; Prof. Arloying, of Lyons, France, Prof. Ravenel, of University of Wisconsin, and Prof. Tendeloc, of Leyden, and others, took issue with him, and seemed to have the facts and figures to prove the transmissibility of bovine tuberculosis to man. A private conference was held in which quite a number of the highest authorities tried to get Prof. Koch to modify his position, but he declined, and the discussion waxed quite warm at times. Had it not been for the respect all felt for him, and personal considerations, a resolution condemning it would have been passed.

The scientific work of the Congress was carried on in seven sections:

Sec. 1.—*Pathology and Bacteriology.*

Pres. Dr. Wm. H. Welch, Baltimore.

Sec. 2.—*Sanatoria, Hospitals and Dispensaries.*

Pres. Dr. Vincent Y. Bowditch, Boston.

Sec. 3.—*Surgery and Orthopedics.*

Pres. Dr. Chas. H. Mayo, Rochester, Minn.

Sec. 4.—*Tuberculosis in Children.*

Pres. Dr. Abram Jacobi, New York.

**Sec. 5.—*Hygiene, Social, Industrial and Economic Aspects of Tuberculosis.***

Pres. Mr. Edward T. Devine, New York.

**Sec. 6.—*State and Municipal Control of Tuberculosis.***

Pres. Surg.-Genl. Walter Wyman, Washington, D. C.

**Sec. 7.—*Tuberculosis in Animals and Its Relation to Man.***

Pres. Dr. Leonard Pearson, Philadelphia.

Of course, it will be impossible even to give a brief summary of the many valuable papers presented in the different sections, for they were all going on at the same time, and one will have to bide the time with patience until the proceedings are published, when one can "read, mark, learn, and inwardly digest" these valuable contributions to the literature on tuberculosis.

The value of tuberculin, not only as a diagnostic agent, but as a curative agent, was generally acknowledged by all, and it is used at Saranac Lake and in nearly all the sanatoria, both in Europe and America. As to the best method of using for diagnostic purposes, whether hypodermically, conjunctival or integumental, there was naturally a difference of opinion. This same difference existed as to amount of reaction and dose to be administered when using as a therapeutic agent, but all showed that progress was being made in treatment. All agreed on the importance of living in the open air, diet, and rest, which can best be had at sanatoria, but can be carried out at home. A change of climate was not considered necessary for the successful treatment of tuberculosis, though it is beneficial in some cases.

The committee on resolutions presented the following, which were adopted as expressed of the sentiment of the Congress.

First.—The attention of state and central governments should be called to the importance of proper laws for the obligatory notification of medical attendants to proper health authorities, of all cases of tuberculosis, coming to their notice, and for the registration of such cases, in order to enable the health authorities to put into operation adequate measures for the prevention of the disease. We urge on the public and all governments the establishment of hospitals for the treatment of advanced cases of tuberculosis.

Second.—We urge the establishment of sanatoria for curable cases of tuberculosis.

Third.—We urge the establishment of dispensaries and day camps, and camps for ambulant cases of tuberculosis which cannot enter hospitals and sanatoria. Again the utmost efforts should be continued in the struggle against tuberculosis, to prevent conveyance from man to man of tuberculous infection, as the most important source of the disease. Further preventive measures must be continued against bovine tuberculosis, and the possibility of the propagation of this to man should be recognized.

Resolved, That this Congress endorses such well considered legislation for the regulation of factories and workshops, the abolition of premature and injurious labor to women and children, and the securing of sanitary dwellings as will increase the resisting power of the individual to tuberculosis and other diseases; that instruction in personal and school hygiene should be given in all schools for the professional training of teachers; that wherever possible such instruction in elementary hygiene should be instructed to properly qualified medical instructors; that colleges and universities should be urged to establish courses in hygiene and sanitation, and also include these subjects among their entrance requirements to stimulate more useful elementary instructions in the lower schools. That this Congress endorses the establishment of play grounds as an important means to preventing tuberculosis through their influence on health and resistance to disease.

A spirit of optimism prevailed the Congress, and its members believed that in time tuberculosis will be under as complete control as small-pox is today. As to when that happy time will arrive, there was quite a diversity of opinion, some of the most sanguine placing it only at thirty years, while the conservatives expected this happy consummation as the crowning victory of their warfare on the Great White Plague by the close of the 20th Century. To accomplish this the medical profession must have the co-operation of the laity, and it was one of the hopeful signs of the progress made, to see the interest manifested in this Congress by such philanthropists as Mr. Henry Phipps, of New York, who has given over a million dollars to aid in the fight on tuberculosis.

The social features of the Congress were very pleasant, and the arrangements and entertainments were all that could have

been desired; and those having these in charge have the congratulations and thanks of all who had the pleasure of attending.

H. R. S.

(It is with pleasure that we are enabled to publish the above review of the recent Congress on Tuberculosis by Dr. H. R. Slack, of LaGrange, who has kindly complied with the editor's request and presented the personal views of a Georgian who is much interested in and thoroughly conversant with tuberculosis and its many different phases).

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### SOUTHERN MEDICAL ASSOCIATION.

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As we go to press the second annual meeting of the Southern Medical Association closes after a most successful meeting. The large attendance, the excellence of the majority of the papers presented by the members in promoting the welfare of the Association clearly indicated continued success and a rapid growth for this body of medical men, which should number among its members every man in our Southland who has any interest in the scientific advancement of the medical profession.

The officers of the association deserve great credit for the success of this meeting, but especial mention should be made of the untiring efforts of Dr. B. L. Wyman, our president; our courteous and able secretary-treasurer, Dr. Oscar Dowling, Shreveport, La., without whose careful attention we could not have heard so many papers by well known Southern physicians. It is with much pleasure that we note the re-election of Dr. Dowling to this position to which he is so well adapted, both by his ability and by his energy in looking out for the interests of the association.

We believe that the time limit for papers should be reduced from 20 to 10 minutes and that, with this reduction and a strict enforcement of the 5 minute limit for discussions, the entire association might meet in a single body where all the papers might be read before the entire association instead of a section. All papers might be condensed so as to be read in 5 or 10 minutes and the additional interest that would follow the reading of short crisp papers would more than justify such a change. This plan would provide a larger audience for all contributors and would tend to educate the members in subjects outside of the

fields in which their own individual efforts confine them in looking out for the best interests of the association.

New Orleans was selected as the next meeting place and the following officers were elected for the ensuing year:

President, Dr. Giles C. Savage, of Nashville, Tenn.; vice-presidents (one from each state): J. M. Jackson, Jr., of Miami, for Florida; Charles M. Murry, of Ripley, for Mississippi; George Dock, of New Orleans, for Louisiana; T. A. Casey, of Birmingham, for Alabama; J. C. Olmstead, of Atlanta, for Georgia, and E. C. Ellett, of Memphis, for Tennessee.

Dr. Oscar Dowling, of Shreveport, La., was re-elected to the office of secretary.

After his induction into office, Dr. Savage, the new president, announced the appointment of the following new councilors for the full three-year term: Dr. W. W. Crawford, of Mississippi, to succeed himself; Dr. B. L. Wyman, of Birmingham, to succeed Dr. D. F. Talley, of Birmingham, and Dr. West, of Chattanooga, to succeed Dr. Savage. The three other councilors are Michael Hoke, of Atlanta; John McDiarmid, of DeLand, Fla., and W. W. Butterworth, of New Orleans. Two of the last named three have one year yet to serve, and the third has two years' service remaining.

The following section officers were elected by the three sections and their names were announced to the general session: Dr. R. G. DuBose, of Mobile, Ala., chairman, and Dr. Jere L. Crook, of Jackson, Tenn., secretary of the section on surgery; Dr. J. A. Witherspoon, of Nashville, Tenn., chairman, and Dr. H. L. Mitchell, of Birmingham, secretary, of the section on medicines, and Dr. A. W. Stirling, of Atlanta, chairman and Dr. A. B. Harris, of Birmingham, secretary, of the section on ophthalmology.

The courtesies extended by the New Kimball were highly appreciated by all connected with the association.

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Dr. De Forest Willard, professor of orthopaedic surgery at the University of Pennsylvania, has been appointed consulting orthopaedic surgeon at the Municipal Hospital, Philadelphia.

## NEWS AND NOTES.

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New Medical Library.—It is announced that the cost of the new medical building for the Medical and Chirurgical Faculty of Maryland will be \$88,000, and of this about \$63,000 has already been subscribed.

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Dr. Charles P. Wertenbaker, of Norfolk, who is attending the convention of military surgeons now in session in this city, was in charge of the United States government health office here during the epidemic of yellow fever in 1905.

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The College of Physicians and Surgeons of Philadelphia announces that the next award of the Alvarenga Prize, amounting to about \$180, will be made July 14, 1909. Essays intended for competition must be received by the secretary of the college by May 1, 1909; each essay must be typewritten; must be without signature; must be plainly marked with a motto; and must be accompanied with a sealed envelope having on its outside the motto of paper, and within the name and address of the author.

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President Ira Remsen of Johns Hopkins University has resigned the directorship of the chemical laboratory, which he has held since the foundation of the University in 1876.

The reports submitted by the surgeons of the various vessels in the Service, on the subject of organization for battle of the medical department of the United States Navy, shows that there is a lack of uniformity in the organization and in the instruction given to the men regarding their stations and duties, which indicates a need for official action. The wide variation in the types of the vessels in the Service makes the formulation of definite regulations somewhat complicated, but it seems probable that

steps will be taken by the Surgeon General to bring about an approximate uniformity of the plan of organization in the establishment of relief and dressing stations on vessels of similar types

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Colonel George H. Torney, now commanding the Army General Hospital at the Presidio of San Francisco, has been nominated to succeed Brigadier General O'Reily as Surgeon General of the United States Army.

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Prof. Irving Fisher, political economist of Yale University, who in one of his papers before the recent International Tuberculosis Congress in Washington, declared that consumption costs the people of the United States more than a billion dollars a year, is preparing an exhaustive report for the National Conservation Commission, which will contain not only these figures, but similar data on the economic loss to the country from all other preventable diseases.

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The authorities of the United States government propose to do much toward educating the public, showing modern appliances and methods of treatment and illustrating the value of sanitary laws and practical hygiene at the Alaska-Yukon-Pacific Exposition which will be held in Seattle in 1909. One of the features of the exhibition of the treasury department in the government building will be that of the Public Health and the Marine Hospital Service.

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The following physicians were noted among those of the Georgia delegation in attendance upon the International Congress on Tuberculosis in Washington, D. C., September 28, October 3rd: Dr. W. E. Adams, Madison; Dr. R. T. Bryant, Turner-ville; Dr. M. A. Clark, Macon; Dr. T. D. Coleman, Augusta; Dr. J. M. Crook, Columbus; Dr. J. W. Duncan, Dr. Frank Eskridge, Dr. Marion McH. Hull, and Dr. Louis C. Rughlin, Atlanta; Dr. W. W. Owens, Savannah; and Dr. Henry R. Slack, LaGrange. Most of these visited the hospitals and sanatoria in New York, Philadelphia and Baltimore before returning home.

REGULAR MEETING FULTON COUNTY MEDICAL  
SOCIETY.

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Carnegie Hall, November 5, at 8 P. M.

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Dr Stirling in chair.

Reported by R. R. Daly, M. D.

*Dr. Andrews* exhibited a case of spinal tuberculosis in a young child for the purpose of showing the differentiation of mixed tubercular infection and making the diagnosis in all early cases.

The forearm of the patient is cleansed with soap and water and ether. Then a drop each of the pure bovine, the pure human and the mixed cultures are placed on the skin about two inches apart.

The epidermis is slightly scarified in the center of each drop, and the reaction waited for. In 18 to 24 hours it appears. If the spot of bovine inoculation reacts, the disease is probably of human infection for these two seem antagonistic, and if the human vaccination is excited, the disease is probably bovine.

It was noted that these tests are without any danger and much less annoying than the reactions obtained from instillations into the eyes, or subcutaneous injections.

They are of greatest value in childhood because in adults, particularly those over 40 years of age, the reaction shows some slight tuberculosis and recalls the German idea that if one has lived long enough, he always has some tuberculosis about him.

*Dr. Duncan* discussed the report and confirmed it with his recent experience at the International Conference at Washington, D. C.

*Dr. Calhoun* asked if the test were of use in the negro. He was answered that the reaction showed plainly enough even if the skin were dark.

*Dr. Fischer* reported a case of Abscess of the Lung and operation upon it.

The young man had pneumonia and grip in 1906, and was sent out West for treatment. He was examined then by several different men who confirmed the diagnosis of phthisis. He improved slightly and returned here five months ago.



He showed area of dullness on left side, had irregular fever and what was supposed to be tubercular sputum.

Twenty-five different examinations were made by several competent men and no tubercular germs were found. The sputum seemed different from that of phthisis; it was noticed to flow more freely from him when leaning forward; the cough came usually in the morning after lying long in one position. These led Dr. Fischer to operate. He did so over the heart apex and opened an abscess in the lung which poured out a pint of very foul pus. The patient made a good recovery and felt much better for 30 days. Then pneumonia in left lung developed. After recovery from this, another area of dullness higher up and nearer the axillary line than the former, was mapped out. The 5th and 6th rib were removed, another foul abscess opened exuding foul pus. The patient recovered and today is well. He was present at the meeting. This case emphasizes the need of careful examination of cases that look so tubercular as to lead one to a preconception they are so. The patient had passed several men who declared him phthisical and indeed his general appearance warranted it. He had passed nearly two years time as a consumptive which might have been spared him. Besides he was in constant danger of death from the unrecognized abscess.

*Dr. Andrews* said that the large abscess cavities suggested a field for the Vaseline-Bismuth-Wax injection.

*Dr. Duncan* related a case of abscess in a negro that was unrecognized till it ruptured.

*Dr. Hodgson's* paper on "Complications of Gonorrhoea in Women" was read by Dr. Ballenger.

Discussed by Dr. Davis who said the subject should be gone over at least once a year if only to keep before the profession the exceeding gravity of the disease. 70 to 80 per cent. of cases in the gynecologic clinic were due to gonorrhoea and at least 40 per cent. in private practice.

The disease is regarded by the public with pernicious levity and they should be made to know that it is difficult to cure.

*Dr. Lokey* suggested that every married woman should be examined for gonorrhoea before parturition to prevent ophthalmia neonatorum.

*Dr. Stirling* said women generally should be informed about this disease before marriage in the hope of securing safety. He

added that the rheumatism in rheumatic iritis was usually of the gonorrhoeal type.

*Dr. Davis* reported a case of uterus bicornis unicollis.

She began to menstruate at 16, was married at 19. She had been fairly regular but often complained of pain in left side. There was some vaginal disturbance which was treated with ichthyol, etc., and got well. Two months later she missed period and showed pregnancy at 6 1-2 months. She had a premature child that died in 4 days. She convalesced only to return in 3 months. She had menstruated once and missed once. There was bloody flow for 3 or 4 days. She flowed again in a month, always complained of left side. The mass previously felt in left side had increased at least four times and it was thought that this was about to cause an abortion. Upon opening abdomen the true condition was disclosed. The unimpregnated horn was pressed upon the left ovary and adherent to it was causing trouble with the pregnant side. The unimpregnated horn and that ovary were removed. She made an uneventful recovery and now is doing nicely at the 7th month expecting to go safely to term.

*Dr. Kime* said operations in pregnant women are getting more frequent and removal of tumors dangerous because of their size are successfully removed.

Committees were appointed for the entertainment of the Southern Medical Society and to investigate the question of caring for all school children.

R. R. DALY.

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## BOOK REVIEWS

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THE READY-REFERENCE HANDBOOK OF DISEASES OF THE SKIN. By George Thomas Jackson, M. D., Chief of Clinic and Instructor in Dermatology, College of Physicians and Surgeons, New York. Sixth edition. 12mo., 737 pages, with 99 engravings and 4 plates, in colors, and monochrome. Cloth, \$3.00, net. Lea & Febiger, Publishers, Philadelphia and New York, 1908.

Since the previous edition of this work, its author has been elected to the full Chair of Dermatology in the College of Phy-

sicians and Surgeons, of New York, a tribute both to the man and to his book. An examination of his pages affords some insight into the reasons for this appreciation. The most obvious characteristic is directness. The author clears the ground in his opening sections on Anatomy, Physiology, General Diagnosis and Therapeutics, and disposes of the moot subject of classification and nomenclature in the briefest and clearest way by means of a table, displaying the various diseases arranged in the most rational system, with the prominent primary lesion mentioned. The reader is now qualified to take up skin diseases in any order, and the most natural and practical is according to the alphabet. Herein lies the "Ready Reference" feature embodied in the title. Each disease is considered in full, beginning with synonyms and proceeding through the symptoms to the etiology, pathology and diagnosis, and to especially full sections on treatment covering all varieties and complications. The book is rich in formulas of proved value in this very trying class of cases. Answering the needs of students, as well as physicians, this work has merited the demand for six editions in sixteen years. It is well established in favor and repays it by frequent revisions, enabling its readers always to keep posted to date.

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A TEXT-BOOK OF PHYSIOLOGY. For Students and Practitioners. By George V. N. Dearborn, A. M., (Harvard), Ph. D., M. D. (Columbia), Professor of Physiology in Tufts College, Medical and Dental Schools, Boston. Octavo, 550 pages, with 300 engravings and 8 colored plates. Cloth, \$3.75 net. Lea & Febiger, Publishers, Philadelphia and New York, 1908.

Professor Dearborn's new work enters its field, already rich in literature, well equipped to achieve a position in the forefront. It is easier to write verbosely than concisely, to state many things rather than to determine what is really important. Our author conceives it to be the duty of a book to guide and instruct a reader presumably unacquainted with its subject beforehand. Instead of turning him loose in a mass of more or less arranged facts, a true text-book should present its principles and data in orderly, logical form, and should also indicate their mutual relations and bearings, so that the student mastering it may have a clear view of

the whole subject. Dr. Dearborn obviously possesses both the requisite physiological knowledge and didactic ability, and his work, manifesting and combining these qualities, is certain to be appreciated by teachers as an excellent text-book for their students, and therefore as a first-class aid in the performance of their own duties.

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**PATHOGENIC MICRO-ORGANISMS, INCLUDING BACTERIA AND PROTOZOA.** A Practical Manual for Students, Physicians and Health Officers. By William H. Park, M. D., Professor of Bacteriology and Hygiene in the University and Bellevue Hospital Medical College, New York. New (third) edition, thoroughly revised and much enlarged. Octavo, 648 pages, with 176 illustrations and 5 full-page plates. Cloth, \$3.75, net. Lea & Febiger, Philadelphia and New York, 1908.

Dr. Park was the first to give concrete recognition in book-form to the fact that diseases caused by animal organisms are almost as important to the human race as those resulting from low forms of vegetable life. It is true that the pathogenic bacteria, representing the vegetable kingdom, are more numerous than the disease-bearing protozoa, or animalcules, and it is also true that the latter are more difficult to cultivate and demonstrate, but no reason can justify ignoring them. Professor Park, perceiving this deficiency, supplied it in the most effective manner by preparing chapters on the protozoa and placing them with others on bacteria in a single volume, where they could be studied together, both in similarity and contrast. His work was thus the first to cover all diseases caused by micro-organisms. The need for it and the acceptable way it supplies that need may be seen in the demand for three editions. In a subject of such intense activity, growth is very great, and accordingly the changes in this new edition are extremely thorough-going. Like its predecessors, it is intended to answer the needs of the student and physicians to cover the whole subject of pathogenic micro-organisms from both standpoints.

**GOLDEN RULES OF DIETETICS.** The General Principles and Emperic Knowledge of Human Nutrition; Analytic Gables of Food Stuffs; Diet Lists and Rules for Infant Feeding and for Feeding in Various Diseases. By A. L. Benedict, A. M., M. D., Buffalo, N. Y. Published by C. V. Mosby, St. Louis. Price \$3.00.

Benedict presents in this volume the general principles of the science and art of dietetics and gives succinct rules for the application of these principles. Being less dogmatic than "Golden Rules" on other subjects published by these publishers, we believe this book is an improvement and will be of distinct value to the physician who will bear in mind its precepts.

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## MEDICAL ITEMS

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The fall season brings cool weather and raw winds. This condition checks elimination through the skin. More work is thrown upon the kidneys. It is not always that they are equal to the extra task imposed. Imperfect elimination is the result. The autotoxic state which soon develops is expressed in either so-called gouty bronchitis, with or without asthma, gouty eczema, recurrent tonsillitis, or rheumatism. To establish adequate elimination is to remove the cause and thus effect a rational cure. The ideal eliminant in such cases is Alkalithia, made by the Keasbey & Mattison Co., Ambler, Pa.

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We wish to acknowledge the receipt of the handsome booklet of Howell Park Sanatorium. Three years ago, Dr. J. Cheston King established this institution for the treatment of nervous and mild emntal diseases, and by his untiring energy and close application to his special line of work, he has enlisted the interest of the medical profession and the patronage of his Sanitarium is not confined to the South alone..

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## **THE LOCAL TREATMENT OF CATARRHAL CONDI- TIONS AFFECTING THE UPPER AIR PASSAGES.**

**BY E. C. ROEMELE, M. D., FRANKFORT, KY.**

Case I.—E. J., aet 24. Diagnosis: Chronic Nasal Catarrh. Duration, three years. Patient complained of a feeling of fullness in the nares and increase of the secretions, the character being thick and greenish, which dropped posteriorly into the pharynx, causing paroxysms of "hawking" which were more marked in the morning just after arising. The voice had a peculiar nasal intonation, the sense of smell was abolished almost entirely and hearing was impaired, due to the extension of the inflammation into the eustachian tubes. The patient also complained of a constant dull headache. I at once prescribed Glyco-Thymoline and had him use the K. & O. Nasal Douche every four

hours, using the Glyco-Thymoline in 25 per cent solution. I directed him to spray his throat with an atomizer, using undiluted Glyco-Thymoline every four hours and also gave him one teaspoonful of Glyco-Thymoline four times a day internally. This was done on account of the catarrhal condition of his stomach. After two weeks the hawking had ceased, his voice took on a more natural tone and hearing and smelling senses were improved. He continued to improve when after fifteen weeks he was entirely cured. There has been no return during the past ten months.

Case II.—Willie Green, aet 7. Diagnosis: Hypertrophy of Tonsils. This case was referred to me by Dr. D., to have his tonsils removed. The doctor stated that he had used every known remedy to reduce them, his last resort being Iodine which he applied in undiluted form, also giving him internal treatment. When I examined his throat I found the tonsils extremely large, so large in fact that the opening was not as large as a slate pencil.

He was a terrible mouth breather and could easily be heard from one room to another. He would not consent to the operation and his mother would not permit us to administer chloroform. I then decided to attempt to cure them without the operation. I prescribed a pound bottle of Glyco-Thymoline and directed the mother to spray his throat thoroughly every three hours with a atomizer. She called in again in one week and the swelling had subsided and the child ceased to breathe as hard as he had breathed. This same treatment was continued. He was returned to my office in three weeks when the tonsils were normal in size; he kept his mouth closed when he slept. The treatment was continued several weeks longer when he was discharged as cured. It has now been eight months and no return whatever of any symptom of the disease.

Case III.—Ella N., aet 27. Diagnosis: Rhino-Pharyngitis. Duration, six years, presenting characteristic symptoms of severe type. Patient had to vomit after each meal on account of hawking the mucus out, which she said would drop into her throat. When she would arise in the morning she would have to hawk and cough half an hour before she would be relieved of the mucus which she said came out of her throat in the shape of round balls. I directed her to use the K. & O. Douche, filling it with Glyco-Thymoline pure, flushing out the nasal cavities three times

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a day and directed her to spray her throat with Glyco-Thymoline, one part to one of water, three times a day. Improvement was immediate. After five weeks instead of using the Glyco-Thymoline in the douche in undiluted form she was directed to dilute it with one part of water. After the fourth day she ceased vomiting and hawking. This treatment was continued, however, for four months when she was discharged cured.

### CHRONIC CONSTIPATION.

Every physician realizes that there are various and diverse causes for chronic constipation, and that no single remedy or combination of remedies will relieve every patient. A large proportion of cases, however, appear to be due to Hepatic Insufficiency and Biliary Stasis. The natural biliary fluid, when sufficient in quality and thin enough to flow freely into the intestine, acts as a physiologic laxative or natural stimulant to peristalsis. *Per contra*, when the bile is not formed and secreted in sufficient quantity, or in its normal condition of fluidity, or when it is deficient in the natural bile acids, a more or less obstinate constipation is likely to result. In such cases, the rational remedy is one which encourages the liver to renewed activity, increases and liquefies the biliary flow, augments the proportion of bile acids in the bile, and thus normally regulates bowel movement.

CHOLOGESTIN efficiently exercises this desirable cholagogue action, as it supplies, in palatable and tolerable form, a sufficient dosage of the anhydrous salt of the natural bile acid (glycocholic acid) to stimulate hepatic activity, and thus promote both bile and bowel drainage. The contained salicylate of sodium (from natural oil of wintergreen) reinforces the cholagogue action of the bile acid salt, and also exercises its well-known liquefying effects upon the biliary fluid. To produce appreciable results, Chologestin must be given regularly for some little time, as it is *not an immediate laxative or cathartic*.

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Of all the office-laboratory tests that the physician is called upon to make, none is of more importance than that employed to detect the presence of indican in the urine. When present in any considerable proportion, this substance is definitely indicative of urine intestinal putrefaction of proteids and constitutes positive evidence of the constitutional absorption of the toxic products of such putrefaction. The symptoms arising from the existence of such an auto-toxemia are vertiably protean in character and upon the extent and duration of this self-poisoning, depends the degree of injury suffered by the organism.

The early detection of a pronounced indicanuria is of great importance to both patient and physician, as it affords the latter a key to efficient treatment, designed to check the putrefactive charges in the bowel and thus prevent the formation and absorption of the toxic products and the consequent intoxication there-

from. Chologestin unquestionably causes the disappearance of urinary indican, by relieving the functional errors causative of same, i. e., Hepatic Insufficiency and Biliary Stasis, combined with proteolytic inactivity of the digestive juices and undue putrefactive changes in the bowel. Chologestin exercises cholagogue, digestive, antiseptic and natural laxative properties. A consideration of the formula will convince any physician that the preparation is carefully designed to meet these special indications for treatment and a clinical trial will demonstrate that the remedy does just what it is intended to do.

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THE FREQUENT, URGENT DESIRE TO URINATE in old men, with some mucus discharge, is relieved by a teaspoonful of sanmetto every three or four hours.

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#### ABDOMINAL APPLICATIONS IN TYPHOID FEVER.

Success in handling a case of typhoid fever may be likened unto the steering of a ship, already in distress, through a dangerous rocky channel. Results depend upon the man whose hand is on the wheel. Lucky be the typhoid fever patient in the hands of a cool, commonsense doctor. It is this sort of a physician who guides his patient through the tortuous, rocky channel of typhoid fever and finally brings him into a safe port.

The many-sidedness of typhoid fever gives it a large interest

## JOURNAL-RECORD OF MEDICINE.

and calls for good judgment. What to do and when to do it, are questions largely determining a physician's success in this infection. The bowels are inflamed, the Peyer's patches being the foci of inflammation, and it is but the application of commonsense principles to seek for some means of combatting this intestinal inflammation.

Local applications prove efficacious elsewhere in inflammation—why not here? Applications with hygroscopic properties reduce inflammations in other tissues of the body and will do likewise in typhoid fever. The best of these is Antiphlogistine and its use in typhoid fever is demonstrable. It will tend to reduce the inflammation and thus contribute in making the typhoid patient comfortable and assist him in his return to health.

Antiphlogistine is applied over the abdomen to the thickness of an eighth of an inch and then covered with a suitable soft cloth. This is renewed twice daily.

This use of Antiphlogistine is a valuable adjunct in the usual treatment of typhoid fever and is a distinct assistance.

—Medical Era.

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## AFTER TYPHOID FEVER.

The convalescent period after typhoid fever is always a trying one. Weakened functions must be coaxed back to normal activity, and every effort made to promote proper nutrition. For many years Gray's Glycerine Tonic Comp. has enjoyed the confidence of the medical profession as a most efficient and satisfactory reconstructive for aiding convalescence. It increases the appetite, raises digestive capacity, and rapidly improves the absorptive and assimilative powers. Thus it offers the most tangible aid to the organism at the time when it needs help the most.

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## SURGICAL CONSCIENCE.\*

BY R. M. HARBIN, M. D., ROME, GA.

In his poem entitled "Latter Day Warnings," Dr. Oliver Wendell Holmes facetiously predicted a millenium:

"When legislators keep the law,  
When preachers tell all they think,  
When lawyers take what they would give.  
And doctors give what they would take,  
Then order your ascension robe."

Were he living today he might add another line: "And surgeons cut only when they would be cut."

While medicine has advanced to the position of a science, at the same time the ethical side of the profession has made corresponding progress and I am optimistic enough to believe so far

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\*Read before the Floyd County Medical Society, Rome, Ga., October 10, 1908.

as the doctor is concerned, that the millenium was not as far away as the physician poet dreamed and that there are many surgeons of the present day who would not do unto others what they would not have done unto themselves.

Yet in our ambitious zeal we are prone to wander away from the golden rule standard and all of us need further advancement in the ethics of our profession.

Billroth once wrote, "Years and experience bring in their train a certain degree of hesitancy," for conservatism is begotten of experience. In all scientific endeavor, strange as it may seem, conservatism is among the last accomplishments—one that is of necessity thrust upon every earnest student of truth. While we are pitying the lack of knowledge of our surgical forefathers, we should not forget that our posterity may pity us in the same way. More progress has been won in surgery in the last twenty five years than had been gained in twenty-five centuries and may it not be that our present attainment is only a beginning?

Surgeons like all true scientists, are earnest seekers of the truth. The truth of the advisability of any operation in question can only be revealed by the subsequent history of the patient operated on, but by painstaking investigation of all the circumstances and a careful review of the histories of previous cases, the result can be foretold with almost positive assurance by a conservative judgment. Of course aberrant cases may arise when no man can predict and such possibilities might be incidentally referred to. Judgment must be broader than zeal and conservatism more prevalent than radicalism. Because operations are radical, gives no guarantee of cure, unless it is clearly proven that a diseased condition of the extirpated organ was a cause of the complaint.

There are cases on the border line when operation is a question of election, such as gall stones, gastric ulcer, uterine fibroids, hernia, etc. We should carefully weigh all reasons for or against operation, and explain and submit to the patient for final approval. If the patient should decline, deal charitably with him, and do not threaten him with sudden death from a ruptured gall bladder, for he may live his allotted term of years. While we are considering the wrongs of radicalism, we must not forget the evils of conservatism. Timid conscience has put many patients beyond the reach of surgical treatment; more especially is

this true of cancer. Our fear of alarming the patient and our hopes of a mistaken diagnosis will rob the patient of the only chance of recovery from an incipient cancer of the breast, for this is the only treatment known to be of value.

We can not but admire the zeal of the specialist. This zeal on the one hand and the ignorance of the patient on the other, often bring about a certain amount of disappointment to both parties.

It is inspiring to the patient to be told by the oculist that a cause of the inveterate headaches has been found which evaded the family physician. The oculist conscientiously believes his diagnosis, but will the subsequent history prove it? The patient meets the same disappointment with the gastrologist and finally consults a surgeon who wonders that an incarcerated ovary had not been thought of, and advises ovariectomy. The surgeon firmly believes his diagnosis, and proceeds with the treatment. The artificial climacteric produces unexpected results and by this time the patient has left the arena of scientific medicine only to adopt some neuro-fad. The patient will excuse a tentative diagnosis in all classes of specialists except surgery and do we not justify the patient?

It may be asked how shall we proceed? After availing himself of all possible knowledge of the patient, the surgeon should explain the probable results, then let the patient or family share the responsibility of what ever decision that may follow and a positive declaration of assent should be secured. It is wise to reduce technical knowledge to the layman's comprehension, then a common sense consultant from the family should become a party to the decision.

We are occasionally asked if we would guarantee a cure from a certain operation. It might be well to reply to such questions that a human life in apparent health cannot be guaranteed under any circumstances. The surgeon should explain the probabilities as he understands them.

My teacher, Dr. J. D. Bryant once remarked to his class that it was not so dangerous to take ether as it was to cross Broadway down town, and it would be well to explain the dangers of an operation by some sort of comparison like that. However, simple an operation may be, we can estimate the degree of danger, but we should never say there is absolutely no danger in any operation.



It seems strange that anaesthetics have received so little attention until recently as a contributing cause of danger in surgery and I do not know but that I had rather be a patient in the hands of a careless surgeon than a careless anaesthetist. In uncomplicated major operations, probably one of the most common contributing causes of shock arises from an unusual susceptibility and over-dosage of the anaesthetic. Using the average amount may be overdosage for some individuals may be a law unto themselves. I recall two uncomplicated cases of this class sustaining shock. One was a case of double tubo-ovarian cyst and the other a pan-hysterectomy for fibroids, the latter having been fatal in twelve hours. Allowing the patient to show resistance occasionally is only a slight inconvenience to the operator and lessens the dangers of a tedious operation.

Some of us conclude at times that it is our duty to operate when the patient comes with a decision already formed. Only recently a woman applied for an examination for fibroid tumors of the uterus and was disappointed when extirpation was not advised because little inconvenience was experienced and she was approaching the menopause. The question of operation on apparently hopeless patients is a difficult one. Surgery is often thus brought into disrepute among some who are even very intelligent.

It may be considered a duty by some surgeons to satisfy patients by saying there was a catarrhal inflammation of the appendix or a cystic ovary when apparently normal organs were removed. Technical language cannot continuously conceal facts from intelligent laymen.

Of course there are difficulties of diagnosis in abdominal surgery that are as yet insurmountable. No diagnostic table can differentiate satisfactorily between gastro-intestinal toxæmia and a fulminating appendicitis within the first few hours and according to the present teachings many normal appendices have been removed, because of the impossibility of diagnosis. An occasional needless operation is no stigma on surgery when many times more lives are saved.

In every profession a certain amount of error is unavoidable and surgery is no exception but it is gratifying that there is being made marked progress in eliminating error.

Operative measures intend to relieve supposed diseased conditions are and should be in themselves practically harmless and no surgeon should ever advise surgical treatment when the operation is as much or more dangerous than the disease itself. These questions are the most difficult and require the most careful deliberation that is ever exacted of the surgeon. The late Dr. Flint was wont to say to his students: "If you can't do your patient any good be sure you don't do any harm" and this injunction would apply to ministers and lawyers as well as physicians and surgeons. No surgeon should advise a laparotomy to establish a diagnosis when he would not be willing to accept the same treatment and all exploratory operations should be explained and it must be remembered that the zeal of the patient is not perhaps so excessive as that of the surgeon in settling certain surgical questions. While we are paying allegiance to the science of medicine we must not forget the interest of the patient for these two interests do exceptionally conflict. We would not wish to prove the hazard of some vaunted procedure on our patients even though it would thus contribute to scientific medicine. An ambitious surgeon may feel that he can never win fame by confining his work to the orthodox teachings of surgery. Be that as it may, the environment of private practice does not warrant such a policy. I once advised the attempt to aspirate the lateral ventricles through a trephined opening after failing to locate a probable abscess of the brain with hemiplegia following grip, the patient having been in an apparently hopeless condition. The experimental nature of the operation was explained. The procedure seemed to relieve and a rapid recovery followed. A fecal impaction with a nucleus of cheese in the caput coli once led me to advise laparotomy for appendical abscess. The patient declined to submit and in a few days the impaction was discharged. When a surgeon makes dogmatic assertions he may become a victim of chagrin. It is not the duty of the surgeon to persuade any sane and intelligent patient into operation. All he should do is to point out the necessity and emphasize the dangers for no surgeon can afford to take the risk of any operation done under forced persuasion.

Note worthy evidence of ethical advancement is marked in the abandonment of an old prejudice that the calling of a consultant is a reflection of the skill of the attending surgeon. It is

gratifying that we now find so few such instances of lack of education. Honest difference of opinions will be productive of good so long as truth and the patient's welfare are subserved, but when any ulterior, selfish motives arise, consultations miscarry. The truth of surgical questions is not written in black and white and even a life long study does not eliminate all errors. Sir Frederick Treves once said that any of his assistants could carry out the technique of his surgical work, but his long experience had not enabled him to always say whether, when or how he should operate.

The safest judgment is not necessarily associated with positive opinions and self opinion may be the cause of many abortive brilliant careers in surgery. Dividing opinion with our confreres is occasionally a method of learning that we unconsciously gain in attempting to be generous.

I am glad to state that I have never heard of the pernicious custom of fee-splitting in our state. Whenever any underhand policy is resorted to, it is only a question of time when the facts will crop out and the results will be embarrassing.

We are often tempted to over charge a grateful patient with ordinary means who has undergone an operation that unquestionably saved a life. The patient is amply grateful and feels that he is paying for his life and at the time may be willing to give a good per cent, of his possessions. An exorbitant fee may be satisfactory for the time being, but later he will become dissatisfied and feel that he had been wronged. The patients ability to pay requires consideration as well as the surgeons skill. A physician's personal necessities should never have any influence in determining the question of charges and for that reason he should practice economy. On the other hand a moral delinquent may be ungrateful for meritorious service and the physician should become one member of society to attempt to correct such defects so far as a tactful policy will allow. A patient may justly feel that he should not pay as much for an operation that fails to relieve as the one that accomplishes its aim, although the same skill was bestowed in both instances and under such circumstances the surgeon should make some concessions. A dissatisfied patient is a menace to the pleasure as well as the success of a surgeon's or physician's work. The free gift of professional services should never be made as such, even to real objects of charity for it tends to crush the remnant efforts at self sustenance for as a rule pay patients are

more grateful than those who never expect any attempts at remuneration. The physician will lend moral support to a charity patient by assuring him that any attempts towards paying will be appreciated and the transaction should never close by making it a free gift. When any one who is financially able accepts without pay, conscientious professional services, which are universally admitted to be worthy of remuneration, he is guilty of robbing the family of the physician or surgeon and it is a duty after explaining the reasonableness of the fee to insist on payment even threatening legal measures, although suing is a doubtful propriety and should be made a last resort. Perhaps the wiser course would be to decline future calls. In fact, the physician is morally reprehensible for failing to attempt collecting reasonable fees for he encourages the beneficiary to get something of recognized value for nothing, to say nothing of the injustice done the other capable, conscientious and energetic members of the profession who depend on their work for a livelihood and a patient who acquiesces in such a transaction deteriorates his sense of honor and becomes less likely to appreciate meritorious services. Pay patients usually monopolize the time of the man who never sends a bill and for that reason he may do less real charity than others. The query arises, would not a capable physician or surgeon accomplish more real charity by collecting his bills and donate a share of his earnings to some good cause. The medical man as the member of a society is expected to pay his debts and in the interest of his patients to devote his entire time to his profession and it would be grossly inconsistent for him not to collect his fees for the laborer is worthy of his hire. Illness as a rule, is no excuse for poverty in the patient for disease is one of the misfortunes of life that requires to be provided for and a man is not expected to earn that money to pay the expense thereof while thus afflicted and anyone who has not provided for such a contingency should be given the opportunity to make amends when restored to health.

Some useful careers in the medical profession have had melancholy endings from failure in paying due regard to the matter of collections. I don't know of anything more pitiable than a physician, who has spent a useful career without preparation for a rainy day and when the infirmities of age circumscribe his activities, he is made to feel that the necessities of the

case compel a greater activity. His weaknesses tend to embitter him toward his life long patients who without due regard to past obligations elect to choose younger and more active members of the profession. Perhaps many of you have heard of a notable exception in the late Dr. Rhett, of Charleston, who was one of the best known surgeons in the South. Having repeatedly heard that something like \$50,000 was raised by popular subscriptions among his friends and patients for his family, I wrote Dr. Lane Mullaly of that city to ascertain the facts. He wrote me that Dr. Rhett was never known to send a bill and that only \$6,000 or \$7,000 was raised principally by those who felt they owed him, for the support of his widow and seven children. Such instances of the donation of conscience money in the medical world are rare and in this instance the amount paid was a mere pittance for doubtless any year of his active life could earn double that amount.

For some unknown psychological reason the matter of collection of fees is repugnant to a great many capable medical men and requires to be overcome as a duty to ourselves, as a debt to our families, and in justice to our patients and profession.

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### ACTIVE EXERCISES IN THE TREATMENT OF LOCOMOTOR ATAXIA.\*

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BY THEODORE TOEPEL, M. D., LECTURER ON MEDICAL GYMNASTICS  
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(Frenckel Method).

Before entering upon the treatment of Tabetic Ataxia it will be necessary for me to make brief mention of the various types of Tabetic Ataxia.

As regards locomotion the following groups may be distinguished:

1. The patient is able to walk about freely, without support, with or without the help of a cane, but his mode of walking is altered.
2. The patient has to lean upon the arm of a companion, with or without the support of a cane; walking alone is impossible.

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3. Walking alone is no longer possible, but the patient can still stand.

4. Walking and standing are impossible. Moreover, at the beginning and at the end of this series should be mentioned on the one hand the so-called pre-ataxia stage and on the other the paralytic stage.

The numerous types of tabetic locomotor disturbance have several symptoms in common, which must be included in the definition of the term "ataxia."

The first is the integrity of the muscular power; the second is the close attention with which the patients follow with their eyes every single movement they make, whether in erect or recumbent position, the third and most important symptom is furnished by the fact that every ataxic movement becomes more pronounced if made with the eyes closed. There are no exceptions from this law, which applies to the erect as well as to the recumbent posture and can be used for the detection of ataxic symptoms in the majority of the patients who are still considered to be in the pre-ataxic stage.

It will be necessary to dwell upon the term "co-ordination" as it forms an important feature in the treatment of tabetic ataxia. The term "co-ordination" denotes the united action of a group of muscles in order to carry out an intended movement; the different degrees of contraction of the various members of a group of muscles may be styled "co-ordination of muscular contraction."

Whereas, it is possible by applying the electric current to stimulate a single muscle to contraction, the numerous individual and groups of muscles are at once combined for common action whenever an intended movement is to be made; in other words, the healthy organism knows only co-ordinate movements.

The factors which produce the co-ordination of the movements are: (1) the quality of the implicated muscle groups, (2) the magnitude of contraction which may be measured with dynamometer, (3) and the celerity of the movement in the joints, which latter depends on the swiftness of the contraction of the muscles.

*Co-ordinate movements can not be made unless the three aforesaid factors work well together.* The slightest irregularity on the part of one of them disturbs the whole movement.

Anatomy describes and names the individual muscles, while the physiology of movements deals with groups of muscles which are distinguished according to their various functions. The contraction of a single muscle (single in an anatomical sense) probably does never occur.

It appears that the will power influences not one muscle, but a group of muscles, which are combined for a common physiological purpose; at least it needs special training in order to enable the will power to influence an individual muscle.

It is by practice only that *dissolated innervation* is acquired, and with it proficiency in the finer kinds of manual labor, and in that kind of leg work which is required in some sports and acrobatic performances.

The muscles which belong to one physiological group differ both as to size and insertion; therefore every individual muscle of the group must, during the execution of an intended movement, enter into a certain, but of course, for each muscle, different state of contraction.

The treatment of locomotor ataxia is based upon the education of the central nervous system by means of repeated exercises, whereby it is enabled to receive sufficiently distant stimuli from the limbs as to their position and so on, although the available quantity of sensation is rather small.

It is necessary, of course, that the movements be attempted and carried out repeatedly and with great attention. Repetition enables the central nervous system to differentiate stimuli of minute intensity; its sensibility becomes so great that often repeated slight stimuli act on it with the same force as rarer but much stronger impressions.

Theoretically, the transformation of an ataxic movement into a normal movement takes place in tabetic subjects according to the same laws as the acquisition in healthy persons of a complicated movement which acquires the differentiation of tactile impressions of minute strength. A certain minimum of sensation, however, is absolutely indispensable; complete anaesthesia precludes the application of the treatment by exercise, but fortunately, such cases are very rarely, if at all, met with.

The greater the loss of sensation the longer and the more difficult will be the treatment and the more uncertain the result.

The principal thing to do in this treatment is to find out for each limb the kind of exercise which is most apt to compensate the loss of sensation. If the loss of sensation has not been so great as to reduce the residue of sensibility below a certain minimum one usually succeeds in teaching the patient to stand or walk with his eyes closed; but the movements will always be more undecided than when they are made under the control of the eyes. We have no means of defining the minimum quantity of sensation which is necessary for producing a good result; but it is sufficient if the patient has a vague sensation of the active or passive movements which are performed by his limbs.

If the patient has a strong will and is able to give close and continued attention to the task he has to perform—a faculty which is much rarer than is commonly supposed—the result of the treatment will be excellent, with that unavoidable exception that the patient must keep his eyes on his movements as it were. Such patients are able, when lying on the back to carry out movements with perfect co-ordination and when walking they walk perfectly well with the single exception that there is more or less hypotonia and curving backward of the knees, or outward rotation of the thighs.

All healthy people move their limbs with a certain amount of steadiness and precision. Tabetics who have undergone the exercise treatment and have lost their ataxia show no obvious differences from the normal state, as long as their attention is not called away from the task they are just performing; but they show a great deal of hesitation and indecision when their attention is directed to something else. In such cases all depends on their determination and endurance; they must continue carefully and persistently to superintend their own movements for many months after their discharge, lest they will quickly return to their former ataxia; for this reason it is better for patients whose initiative and will power is weak to remain under observation for some months after the treatment proper has been concluded, until they have completely mastered their daily task and have acquired the habit of continuous and painstaking supervision of every detail of their movements. If the exercises are practiced daily with the same attention, the movements continue to gain precision.



The exercises may be classified according to the various functions of the affected limbs, and according to the manner and degree of ataxia.

As regards the various degrees and forms of ataxia, it makes it obligatory upon the physician to choose the exercises which are most suitable in each case, and intensity to the sequence, duration and intensity to the requirements of each individual case.

The exercises are divided into:

1. Those that are practiced in the recumbent position—in which the influence of gravitation and the necessity of keeping the equilibrium may be eliminated.
2. Those that take place when the patient is in a sitting position.
3. Those that are executed by the patient in an erect position.
4. Those which consist in various movements and evolutions carried on during walking.

Exercises in recumbent position.

Both legs are stretched out.

1. Flexion of one leg to different angles.
2. Same as 1, with abduction and adduction.
3. With sudden halting in the midst of the movement, the doctor giving the command.
4. The patient making a voluntary halt in the midst of flexion or extension.
5. Both legs—repeat 1, 2, 3 and 4.

Movements are made slowly and even. Repeat each exercise about 4 times at the beginning then increase the repetition slowly.

Keep leg moving in a vertical plane. In tabetic patient's legs can be flexed high on chest. Only flex as high so that heel touches other knee.

6. Repeat exercises 1-5, but keep heel off the couch.
7. Heel is placed on patella on other side then on different places of the tibia the ankle joint on the toes.  
Strap garters with different colored pads to the legs.
8. Heels slide up and down the tibia, call halts at different places during the exercises.
9. The leg is flexed in the hip and knee to a right angle, then extend knee joint.

10. Both legs are flexed, both knees and inner malleoli remain in apposition.
11. With voluntary halts by the patient and by the doctor.
12. See saw, flexion and extension (alternate).
13. One leg is flexed while the other leg is abducted—extension of flexed and adduction of abducted.
14. Place heel on knee, follow course of tibia without touching down and back again.
15. The patient tries to place his heel in the hollow of the doctors hand, which constantly changes its position.
16. Exercises in bed with special apparatus. Bar—high and low. Board with notches which are numbered. Board with two rows of holes. Large and small rings—foot follows the circumference of this ring.
17. Repeat exercises, the eyes fixed on some object in the room. Assume sitting position and repeat exercises 1-17.
18. Sitting down and getting up. Erect position.
19. Walking slowly, watching closely the way he moves and correcting the outer rotation of his legs.
20. Steps of 6 inches, 14, 24 inches should be taken slowly—the patient dressed so that he can watch the movement well. To get the distance have oil cloth with foot prints painted on. Use walking sticks. Fix eyes on prints and feet.
21. The long step, 28 inches in reserved for the last. This requires good control. The half step, 14 inches. The quarter step, 7 inches.
22. Single step forward (that is, after each step the feet are placed in apposition.)
23. Steps 1-2, 1-4, progression.
24. Combine steps of unequal lengths.
25. Stepping sideways.
26. Stepping backwards.
27. Change of direction—turning around.
28. Walking zig zag.
29. Walking with bent knees.
30. Walking on the narrow border.
30. Walking with objects in their hands—on the head.
31. The walking in cases of severe ataxia is with belt around thorax supported by two attendants—walking on the spot first exercise.

## MALARIA.\*

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BY D. H. DU PREE, B. S., M. D., ATHENS, GA.

I chose this subject because malaria presents some interesting problems in diagnosis, and because several of its forms have attacked me at one time and another. The differentiation between aestivo-autumal malaria and typhoid I shall attempt to emphasize, simply mentioning the pathology of the disease, and neglecting the treatment entirely. It is an old subject, but in the next few months some of us will be called on to make the diagnosis in a case of continued fever, and this is the excuse for these remarks.

We shall waive the definition of paludism and pass on to a description of the parasite, the recognition of which is the most important point in the diagnosis. As you know, in 1880, Laeran discovered this haemacytozoon, and a number of observers found it invariably associated with malaria. Later Bolgi differentiated the three varieties, and Ross, MacCallum, and Manson showed that man was infected by the bite of a mosquito, the definite host of the parasite.

The parasite in man attacks the red blood corpuscles, and there undergoes segmentation and sporulation, with the formation of comparatively few sexual elements.

In its early stages the parasite of tertian malaria, *Plasmodium vivax* (*Haemamoeba vivax*), is small, round and not pigmented. It is actively amoeboid and frequently assumes the shape of a signet ring. The nucleus is relatively large and clear. As it grows pigment appears in its cytoplasm in small granules. The invaded corpuscles are not changed in appearance at first, but become swollen and anaemic. As the plasmodium reaches maturity, it becomes almost as large as the red blood cell containing it; it gathers its pigment towards its center; and finally divides into fifteen or twenty segments that are identical with the small round bodies with which we began this description. The red blood cell is disintegrated, and the pigment of the parasite is scattered in the blood-stream to be ingested by phagocytes, or to lodge in the liver and spleen. The small hyaline bodies thus set free infect other corpuscles. Only a few sexual elements are formed, which are peculiar bodies and are known as microgame-

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toocytes (male) and macrogametocytes (female). This process takes about 48 hours for its completion, and the paroxysm is coincident with the segmentation and sporulation of the plasmodium. As this paroxysm occurs therefore every other day, this is known clinically as Tertian Malaria.

The parasite of quartan malaria, *plasmodium malariae* (*haemamoeba malariae*), is like *P. vivax* in the regularity of its cyclic development and in its general appearance. However, it is not so actively amoeboid, and its pigment granules are coarser. The infected haematocytes are shrunken and brassy in appearance. It divides into only six or eight segments, and its cycle of development lasts about 72 hours. Hence the paroxysm occurs every fourth day, and it derives the name Quartan Malaria from this fact. It is not so common as *P. vivax*.

A patient may receive a double infection with *P. vivax* and then he will develop a paroxysm with the maturation of each set—every 24 hours—Quotidian Malaria. Sometimes he may harbor two or (rarely) more sets of *P. malariae*. Often there is a mixed infection with *vivax* and *malariae*.

The parasite of destivo-autumnal malaria, *plasmodium praecox* (*haematozoon falciparum*), is smaller than the others, its pigment is scantier, and the corpuscle containing it is brassy in appearance and not increased in size. The later stages disappear from the peripheral circulation and stay pretty closely in blood of certain internal organs, especially in the spleen and bone-marrow. After a week or ten days crescents and ovoids with pigment in their centers appear in the circulating blood, and these are characteristic of this form of malaria. They are the sexual forms of the parasite. Unlike the others it does not develop in regular cycles, and this is the cause of the irregular clinical manifestations.

This organism does not exist in nature except as a parasite in man, its intermediate host, and in the mosquito, its definite host. And the only mosquito that harbors it is the genus *Anopheles*. This mosquito is confined chiefly to the country, as it breeds only in puddles and sluggish streams. It flies mostly at night. It can be distinguished from *Culex*, or the common mosquito, by the facts that its palpi are almost as long as its proboscis, so that it appears to have three proboscides; the palpi of *Culex* are short. The wings of *Anopheles* are mottled, of *Culex*

plain. Anopheles stands with its body at an angle to the supporting surface; culex stands with its body parallel to the surface upon which it rests, with its hind legs drawn up to its body.

When a mosquito belonging to this genus anopheles bites a patient infected with malaria, the parasite is ingested along with the patient's blood. It invades the stomach-wall of its new host and there undergoes its sexual development. When this process is completed, the oöcyst bursts into the body-cavity, and the spores find their way to the salivary glands and ducts, and are injected into the blood of the next victim of the mosquito. So the cycle is completed, sexual in man, sexual in the mosquito.

Let us dismiss the pathology of the condition by saying that the essentials are a disintegration of the red blood corpuscles, enlargement of the spleen, toxæmia; and in severe cases, a grave anaemia, often a nephritis, accumulation of pigment in some internal organs, etc. We are more concerned here with the diagnosis.

The recognition of the regular Tertian, Quartain and Quotidian types is an easy matter, and does not often puzzle even the laity. There is the regularly recurring chill, followed by fever, which is "sweated off," after which the patient is fairly comfortable, or even apparently well if he possesses a phlegmatic temperament, until the next paroxysm.

It is the aestivo-autumnal that is so often puzzling. Its clinical manifestations may vary from a mild attack of intermittent fever to the pernicious types of chronic malaria, "black-water fever" or fulminating malaria, types that the fortunately becoming rare in this part of the world. It may simulate typhoid so closely that it is well nigh impossible to make a diagnosis without the aid of a microscope. The symptoms are irregular. There may be fever intermitting at irregular intervals. The initial chill of the paroxysm is often absent, and the fall in temperature as often by lysis as by crisis. The fever may be without intermission and may persist for two or three days or a couple of weeks, after which the patient may recover or go into a pernicious malaria. The paroxysms may anticipate. There is enlargement of the spleen, and frequently an initial bronchitis, as in typhoid. The patient *looks sick* like a typhoid. And the cases usually occur in the autumn—as the name indicates—along with typhoid. However, these cases of malaria with continued fever,

usually begin with several intermittent paroxysms. Herpes labialis is more common in malaria. Intestinal symptoms are not so marked as in typhoid and the rose spots of the latter are not observed. The Widal reaction is negative in those patients who have never had typhoid, and crescents and ovoids are seen in the red blood cells. There is a secondary anaemia in both diseases, but in aestivo-autumnal malaria there is lacking the leucopenia and relative lymphocytosis characteristic of typhoid. Ehrlich's diazo reaction is positive in typhoid and negative in malaria. In cases of doubt, when the blood examination cannot be made, the therapeutic test with quinine may be resorted to. But where it can be done the examination of the blood is the surest method of differentiation. As Osler remarks, "one crescent makes a diagnosis."

Aestivo-autumnal malaria may be mistaken for general military tuberculosis, and vice versa, and here too, the surest method of diagnosis is the examination of the blood. The diazo reaction is positive in tuberculosis.

In the study of malaria and typhoid in the Johns Hopkins Hospital one case out of a series of 829 typhoids showed malarial parasites during the course of the disease.

The differential diagnosis between these two diseases interests me particularly because I have seen several cases of typhoid complicated with a distressing cinchonism and one case of pernicious malaria die under typhoid treatment.

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### TRACHEOBRONCHOSCOPY AND OESOPHAGOSCOPY.\*

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BY OTIS H. JOHNSON, B. A., M. D., ATHENS, GA.

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Until quite recently direct inspection of the larynx and trachea has been possible only in a very limited and imperfect manner, by means of mirrors, and the removal of foreign bodies lodged in the lower portions of the trachea or oesophagus, or in the bronchial tubes, was well-nigh impossible without an incision. But, thanks to the genius of Professor Killain, of Freiburg, we now have, in his bronchoscope, an instrument by which we can in-

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spect every portion of the larynx, trachea, bronchi, and even *bronchioles*, the oesophagus, and the greater part of the stomach, extract foreign bodies from these structures, make topical applications, or remove morbid growths. Formerly a foreign body in the bronchial tubes was almost certain to cause death eventually, unless coughed up, but now it is a comparatively simple matter to remove it through the long tube of the bronchoscope, by means of specially devised forceps.

Professor Killian's instrument, of which there are several modifications, consists of a number of tubes of varying lengths and calibers, one of which is attached to a handle containing a miniature incandescent light, the rays from which are reflected through the tube by means of a fixed mirror, shielded from the eyes of the operator. The American bronchoscope, originally devised by Dr. Chevalier Jackson, and highly recommended by Kyle and Ballenger, differs from the German instrument in that the light is furnished by a tiny incandescent light at the distal end of the tube, instead of in the handle, and supplied by wires running through a conduit in the walls of the tube. The German type seems to be the more practical, as the light in the distal end of the American tube takes up valuable space, and is liable to be obscured by blood and secretions during the operation, while the light in the handle of the German tube cannot possibly be reached by secretions.

Bronchoscopy is usually required for the extraction of foreign bodies more than for any other purpose, though it is also used for the local application of weak solutions of silver nitrate in ulcerated and chronic conditions of the larynx and trachea, and for diagnostic purposes. It is practised upon children with as much success as upon adults, and is more often needed for them, since their universal habit of testing articles with the mouth brings about a large number of bronchial foreign body cases as a sequel. Also the danger is greater in the case of an infant, on account of the smaller size of the respiratory tubes, and the chance of immediate suffocation if not relieved.

A foreign body in the respiratory tract generally causes violent choking and suffocation at first, with cyanosis and aphonia, but these symptoms may subside, and not return for several hours or days. The cough may become constant, the patient loses weight, and there is frequently every symptom of pulmonary tuberculosis, except the presence of the bacillus.

According to Ballenger, "a history of spasmodic cough, dyspnoea and hoarseness, followed by a persistent cough, should excite suspicion of a foreign body in the respiratory tract if the patient is a small child."

Kyle and Johnson agree that "many curious cases of persistent cough and obscure bronchial or so-called lung trouble could be traced to some foreign body. The bronchial irritation or the persistent hacking cough may be due to the lodgement or some foreign body in the upper respiratory tract, or in the oesophagus."

No time should be lost in attempting to remove a foreign body from the respiratory passages, for at any moment it may assume a more unfavorable position and cause sudden death, or its long continued presence may cause local oedema, septic absorption, or pneumonia. If necessary, tracheotomy should be resorted to, in order to relieve the suffocative dyspnoea, though this will be useless if the foreign body is in the lower respiratory tract. The practice of thumping a person upon the back when choked, a method which is universally resorted to by the laity, while sometimes successful, is nevertheless dangerous, for it may force the foreign body into a worse position and cause immediate suffocation. It is better to take the patient to a physician at once, without trying to remove it, and, if it cannot be removed by using laryngeal forceps and mirror, recourse should be had to the bronchoscope without delay.

There are two methods of bronchoscopy, *upper*, in which the tubes is introduced through the mouth, and *lower*, in which it is introduced through a tracheal incision. The former is practised in all cases, and the latter where the former has failed, a larger and shorter tube being used in the lower operation.

Upper bronchoscopy can be performed either under cocaine or with a general anaesthetic, ether being preferable to chlorform. The German operators prefer to pass the tube after a local application of cocaine, made first as a four per cent. spray, then as a twenty per cent. swab to the pharynx and larynx, and lastly, through the bronchoscope, as a ten per cent. swab to the trachea, but this can successfully be done only upon the stolid patient of a hospital clinic, and it will not do in private practice, nor especially upon children. In this method the patient is seated, his head thrown far back and seated by an assistant, the operator standing in front and over him.



With a general anaesthetic, the patient is only partially anesthetized, in the dorsal position, and the head hangs over the end of the table, being supported by the assistant. Another assistant stands near with a bunch of long cotton swabs to remove secretions and cleanse the tube, or he may use Jackson's exhaust pump for removing saliva. The surgeon sits upon a low stool, or kneels upon the floor, at the patients head. A tube of the necessary length and caliber having been chosen, a mouthgag is inserted, and the tube passes down as far as the vocal cords, then held for an instant until it can be slipped between and past the cords during an inspiration. Now the trachea is swabbed, through the tube, with a ten per cent. solution of cocaine, to lessen reflex irritation, and the tube is slowly passed down the trachea, while the surgeon keeps a careful eye upon its course, until the tracheal bifurcation is reached; then, if the right bronchus is to be explored, the tube is tilted to the left and passed on, and if the left is to be inspected, tilted to the right, the elasticity of the trachea and bronchi allowing considerable manipulation without damage. Thus the bronchioles may be examined in every direction, and the foreign body located. A pair of long-shaken forceps is introduced through the tube, and the offending object removed.

If the operator fails to find the foreign body, and thinks he can do so by lower bronchoscopy, or if he locates it and it is too large for removal by the upper route, he performs a low tracheotomy, introduces the tube through the wound and proceeds with the examination. This method is less likely to result in pulmonary complications, but is necessarily a more drastic procedure than upper bronchoscopy. The patient occupies the same dorsal position as in the upper operation, with the head hanging over the end and supported by an assistant. Strict asepsis must be observed in lower bronchoscopy, as in any other operation, and the wound must be well cleansed from blood before inserting the tube. After the operation a tracheotomy tube is kept in the wound for several days, and the patient is urged to sit up as soon as possible, to avoid pneumonia. The same instrument is used in examining the oesophagus, except that a mandrin or obturator must be used until the cricoid cartilage is passed, and the technique is practically the same as in bronchoscopy. Care must be taken, however, not to tilt the tube forward and compress the trachea..

Cases of a foreign body in the respiratory passage of oesophagus, which can be brought to the surgeon for bronchoscopic treatment are rather rare in private practice, and it is possible that the average specialist will never encounter a case; but every time a foreign body is extracted by the use of the bronchoscope a life is saved which would undoubtedly perish otherwise. Professor Killian has reported eighteen cases in which he attempted to remove a foreign body by this method, and in fifteen he was entirely successful. In two he failed to find the foreign body, and one other died of pulmonary complications six months after removal.

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## ETIOLOGY, INFECTION CARRIERS, AND TREATMENT OF TYPHOID FEVER.\*

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BY B. W. HALL, M. D., BOWMAN, GA.

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In surgery, the art and science of the practice of medicine, typhoid fever included, we are learning to unlearn former ideas and theories. The crude in all science, art and philosophy is rapidly having the search light turned on in order to establish elementary facts.

According to historical descriptions of fever in the days of hipocrates it was not ristorical descriptions of fever in the days of seventeenth century it was regarded more as a symptom of a distinct condition rather than as a disease. In France and England, during the latter part of the eighteenth and early part of the nineteenth century, typhoid fever became more fully understood as a disease separate and distinct from typhus fever. Its causes and pathological anatomy became more fully understood.

In this brief sketch of typhoid fever I will eliminate as much as possible theoretical knowledge except that which bears directly upon the establishment of commonly accepted elementary facts.

Guessing now, little clouds the way in the diagnosis of typhoid fever. The experienced bacteriologist and pathologist can usually speedily settle all doubt in the diagnosis. The state, municipal and national government have already made considerable progress in the eradication of typhoid and other fever infections

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and still greater progress is possible by instituting legal and hygienic rules of more force than they ever have done hitherto.

Formally, when physicians did not know just how this disease was communicated, it was considered inevitable and every one expected to have it sooner or later. Many persons actually believed it served a good purpose in cleansing the system in the event the patient recovered.

It is now an undisputed fact that typhoid fever is caused by a specific bacillus which enters the system through the mouth and the only cleansing which takes place is done, not by the disease, but when nature and medicine clear the system of toxins and infection.

For many years it was thought that a chemic poison produced by certain putrefactive substances caused typhoid fever. The old putrefactive theory has some well grounded truths. But the general accepted idea now held is that there is a direct infection by a specific bacillus or organism, which is taken into the system through the water or food.

It is an agent of specific origin and specific action. No case of typhoid originates spontaneously, but every case has an antecedent cause. The typhoid germs may be spread by the patient himself. Hence disinfection of the stools is absolutely essential in order to stop the spread of the disease.

Among local causes may be mentioned, extensive excavations of earth, low level of ground water, polluted drinking water, infected milk or polluted food.

Carriers.—(1) water, (2) house fly, (3) food or milk, (4) persons themselves, (5) air, (6) dust, (7) unsanitary clothing.

A 10 per cent. solution of formaldehyde will destroy the house fly, when placed in rooms or in the dining rooms. Milk laws in cities will prevent infection from that source.

In cities where infections are known to exist, bottle water is always procurable by persons who can afford to buy. But the vast majority can not afford to buy table water when the full supply is contaminated, and the average citizen trusts to luck rather than take the trouble of providing against disaster. He declines to boil his drinking water even during the presence of an epidemic or when the health officer calls his attention to the necessity of doing so.

Typhoid fever is not prominent in the list of fatal diseases. The percentages of fatalities is unusually small, but the disease entails long illness, requires careful nursing and is a heavy expense to every family it attacks.

Unlike many infections, typhoid fever may come from the country to the city; from the large to the smaller villages. Careless nursing of one case may pollute the water supply of an adjacent town and produce an epidemic of large proportions.

Even after physicians discovered the means by which typhoid fever is communicated it was generally believed that water, free from visible impurities, was safe and that visible foul water was dangerous.

Although the latter conclusion is generally correct the former is wholly erroneous. When a city's water supply comes directly from a muddy stream the probabilities are that it contains the infection as typhoid fever is existent at all times and streams are open to pollution from many sources, but perfectly clear water having every appearance of purity may be more dangerous than muddy water. The house filter clarifies, but does not actually cleanse.

Bacteria may be eliminated from water only by an elaborate system of municipal filtration or by thorough boiling.

An illustration of the truth of this fact was offered recently when typhoid fever became prevalent in a fashionable quarter of an American city where bottled water was used almost exclusively for drinking. Investigation showed that the water came from a "spring" upon the property of the dealer. Bacteriologists discovered that the water contained typhoid bacilli and further investigation showed that the "spring" was a leak from a sewer.

It will be seen that the water was filtered through several yards of earth, had been made perfectly clear and apparently pure, without eliminating the bacteria.

This is as much as an ordinary house filter can be expected to do.

American triumphs in the Panama canal zone which in 1905 were hot beds of disease, are now, after three years' of hospital supervision, transformed into practically new cities, by means of applying well known hygienic health laws and modern hospitals, installing pure water and a well regulated sewerage system.

In the London Lancet of June 27, 1908, pleasure seekers are warned against the dangers of the deadly holidays spent away from cities. Among other things, the Lancet goes on to state that almost every detail of a holiday is emphasized except the all-important question of hygiene. In these deadly holidays, families are frequently plunged into death traps at seaside or country village resorts. The natives of these seaside or country village resorts have become immune to these infected vicinities. Whereas the holiday, pleasure seeker, not accustomed to the impure water and unsanitary conditions, quickly become infected.

Instances are not wanting where soldiers just passing through these infected areas have taken typhoid fever, whereas the natives were not the least affected with the disease.

The boy who lives over the unsanitary stable is often healthy enough, but this method of living suddenly introduced to a person used to a carefully guarded sanitary environment, might prove to be a serious menace to his health.

In the City of Pittsburg, Penn., after thoroughly purifying the water supply and disinfecting all known causes of typhoid fever, an elderly lady who six years previously had been in an infected district communicated the disease to another family.

In the City of Georgetown, a suburb of Washington, D. C., a patient communicated the disease this summer after having acted as carrier 18 years. Further investigation on this point develops the fact that two per cent. of all convalescent cases of typhoid acts as carriers.

Individuals living in an infected location, may develop fever one summer, while others will escape and then may develop fever the summer following. An infected, vacated house frequently carries fever one year later to the incoming family.

As previously stated, a specific bacteria of direct transmission, demonstrated by pathologist and bacteriologist, has become the accepted etiological factor in the development of typhoid fever.

Theorizing from cause to effect Elberth in 1880 discovered the *bacillus typhosus*. Gaffky and many other bacteriologists have confirmed the discoveries of Eberth. Gaffky was the first to present a firm foundation for bacteriological isolation and growing of pure culture from healthy individuals to formulate the definite conclusion that the organism is the specific cause of typhoid fever.

The bacilli of Elberth in their ordinary form, are short, thick rods with rounded extremities and about thrice as long as they are wide and in length are one-third the diameter of a red blood corpuscle.

From recent scientific investigations it will be observed that the Elberth-Gaffky bacillus is not identical with the bacillus calli. It will take further definite scientific proof to settle this question.

In all cases of doubtful diagnosis a bacteriological investigation by means of applying the "Widal Test" will determine the presence or absence of the bacillus typhosus. It has been the experience of bacteriologists that all culture media of the typhoid bacillus thrive best at body temperature of 98.2-5 or 37.0 C.

The Widal Serum Test for Typhoid Fever.

One part blood from a suspected case to 10 parts bouillon culture of typhoid bacilli. If culture is fresh and serum that of a person with typhoid fever, the bacilli collect in groups (called clumping), followed by mortillity of the bacteria.

The different types of typhoid are the ambulatory or walking typhoid. Hemorrhagic typhoid, para-typhoid and mixed infection of typhoid and malaria.

Typhoid fever is not contagious, but an infectious disease and always maintains a tendency to local limitations and is only altered by special conditions.

It is world wide in its distribution—no race, climate or altitude being exempt, and depends upon human activity for its distribution.

It has been observed in all civilized countries of the earth and the most varied climates and altitudes.

Typhoid fever costs the people of the United States alone, annually, \$200,000,000. Reasoning from cause to effect, Georgia's pro rata part of this amount would be approximately \$8,782,222. This gives us an idea of how much money is expended for the suppression of typhoid fever to say nothing of the loss of thousand of valuable human lives and untold suffering it occasions.

This vast sum is the cost of negligence. With proper precaution the individual may almost surely escape infection, and by co-operation in city, town, country, state, and national government it could be stamped out by means of well organized state and national Public Health Boards.

Copper sulphate could be used on a large scale to destroy typhoid fever bacteria in large lakes, rivers, ponds and cesspools. Milk of lime could be used in the inner walls of houses, residents and tenements of all kinds.

**First.**—Apply general rules for the protection of entire cities or entire districts.

**Second.**—Apply special individual measures to stop the transmission of bacteria by carriers.

**Third.**—Preventive inoculation to make persons immune by the Wright and Netly vaccination method.

By this method persons are vaccinated against typhoid fever infection and rendered immune.

This method of rendering persons immune was first proved successful in the Boer War in South Africa, and is worthy of adoption by our state and National Health Boards. The period of incubation of the typhoid fever may vary from 10 to 20 days and may be accompanied by a chill, general malaise followed by fever.

Typhoid may vary from the mildest walking type to the severest malignant or hemorrhagic type or until death may close the scene.

The symptoms and pathological anatomy are very familiar to the profession. Complications of typhoid fever are as broad as the science of medicine itself. From the Peyers patches of the small intestines, the pathology may extend to the liver, brain and nervous system, lungs, spleen, kidneys, and joints.

Conservatism and fighting shy of all harmful drugs is the one great essential in the treatment of typhoid fever.

We are taking it for granted that the physician in charge has studied the action of all drugs he uses as his weapons of warfare. Also that he understands fully the family history temperaments and stamina of his patient.

An able and experienced physician and nurse is the key to the entire situation in a severe case of typhoid fever.

Poor nursing, underfeeding, venereal habits and unfavorable circumstances, render practice among colored people unsatisfactory. All cases of typhoid fever demanding treatment should be enjoined to go to bed and remain quiet. Malignant and hemorrhagic cases should use a bed pan.

I very often give a teaspoonful every 4 hours of alcoholic or dycerinized solution (rendered neutral) of thymol, menthol, eucalyptol, salicylic, benzoic and boracic acid. In the interval between the above antiseptic mixture I have been very successful with 10 to 20 drops fl. ex. Echinacae, either with or without sulphate of strychnine.

Or varying the treatment I add 4 to 5 grains bismuth every 4 hours and antiseptic mixture between the bismuth.

If necessary echinacae and sulphate of strychnine every 6 hours.

The best haemostatic and "bug killer" is aromatic sulphuric acid,

Expistaxis intestinal hemorrhage and purpura hemorrhagica are controlled by sulphuric acid. Strychnine sulphate may be combined with it in the proportion 7 to 12 drops aromatic sulphuric acid and 1-16 gr. sulphate strychnine to the teaspoonful.

In blood poison, gangrene and typhoid fever, spirits turpentine stands at the head of all germicidal remedies. I have almost ceased using turpentine emulsion and depend on one thorough local application to the bowels, daily, in typhoid fever inflammation.

Ethol may be used for its antiseptic effect instead of echinacae.

In inflammations, peritonitis I use hot cloths, turpentine stupes, antiseptic plasters or cataplasms, vinegar and bran poultices. If the kidneys become ingorged I use the diuretics. For a depressed heart circulation attended with delirium, I use a combination of sulphate of strychnine, nitro-glycerine and digitalin. For intestinal hemorrhage I use large doses of bismuth internally. Morphine and atropine sulphate hypodermically to control the pain. Stimulants and nourishments to fortify against threatened collapse. If the cutaneous circulation is very weak, hot, dry surface with threatened enlarged glands of the throat, I sponge once or twice daily with a 45 or 50 per cent. solution of alcohol.

I never use subnitrate of bismuth and aromatic sulphuric acid at the same time, but alternate them. I withdraw the use of any drug which acts in any way unpleasant. In hemorrhagic conditions and inflammation of the bowels, I frequently resort to irrigation of the bowels, using normal salt solution or antiseptics



enaemas. I do not use salts or Seidlitz powders, but prefer castor oil as a laxative. I do not use quinine sulphate as an antipyretic, but use it as a tonic in the convalescent stage. When I can watch its effects I sometimes use Zomakyne as a fever antipyretic. I keep a chart and have medicines given by the clock. I have my patients sponged or bathed from one to 3 times daily as conditions demand. It is useless to conclude that a barrel of butter milk will cure typhoid fever unless you add something to "kill bugs."

I use some one of the following diets and vary them according to the needs and appetites of my patients: Wild game, bird or chicken, or beef soups, sweet or butter milk, grape juice, blackberry juice, pepsi elixirs, peptonoids, protein meat-broths, eggs, syrups, fruit juices of orange, lemon, raspberry, albumen.

In the year 1904, I attended 27 cases of typhoid fever near the village of Bowman, Ga. These cases varied from the mildest walking fever to the most malignant and complicated. About 5 cases developed nose bleed and intestinal hemorrhage. One case was mixed-traumatism and fever, which died, one case died from haematuria, one case died from sepsis and toxæmia with engorgement of the lung, one case died from malignancy. All hemorrhagic (intestinal) ipistoxis cases recovered. Out of a total of 27 cases only 4 died.

In the preparation of this article some reference was made by the writer to *The Literary Digest*, published by Funk & Wagnalls, New York, also *Nathnagles Encyclopedia of Practical Medicine*.

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The Supreme Court of Georgia had just decided that when an employer summons a physician to care for an employe who has become suddenly ill, the employer is not liable for the bill unless there is a definite agreement between the employer and employe that the former shall be liable.

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At the recent celebration of "Academic Day" of the University of Maryland it was decided to erect a tablet in memory of the late Major James Carroll, of the Army Medical Corps, who received his diploma from this university.

# EDITORIALS

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The Business Office of the JOURNAL-RECORD is 1 1-2 to 5 1-2 South Broad Street. The Editorial Office is 1014-15 Century Building. Address all Business Communications to *Journal-Record of Medicine*, 1 1-2 to 5 1-2 South Broad Street.

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## A SCHEDULE OF MEDICAL FEES.

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Early in the year which is approaching its end the Fulton County Medical Society appointed two committees, called respectively, the Collection Committee and the Regulation of Fees Committee. The work of the former obtained an unexpected notoriety from being scented by the keen nose of a newspaper young gentleman whose official armament includes an exuberant and uncurbed fancy unclouded by any special development of the organs of either gratitude or veneration and untrammelled by the least caring as to the probable effect of his exploration of what promised an hour's sensation. In a brilliant effort to be funny and entertaining, the profession was represented as suddenly seized by a craze for money-getting which had cut it off from that charity with which till now it had overflowed into the laps of many even of those who were totally undeserving. But the publicity thus produced, in spite of and perhaps to some extent on account of the manner of its production had on the whole a beneficial effect and evoked from the laity many expressions of sympathy with the position of the profession in regard to its innovation. The work of the committee on the Regulation of Fees is not complete, and will doubtless be carried on into next year. It is interesting in the mean time to observe that Dr. J. N. McCormack, the official organiser of the American Medical Association, has recently produced "a general plan for a Schedule of Medical Fees" whose methods very much resemble those of the Fulton County Society. He says, "I am advising that the profession in each county or city consider the advisability of arranging for systematic monthly collections, with a carefully selected business-

representative, and a centrally located medical collector's office, the collector to be under bond, and on a definite salary, and with authority to appoint as many assistants as may be necessary, for whom he is responsible, very much as sheriffs and city collectors do." Dr. McCormack lays stress upon the present general inadequacy of medical fees and suggests a schedule which could be modified to suit local conditions, and which should be framed according to the cost of living and of modern medical equipment, which have respectively doubled and quadrupled in recent years. These fees, he thinks, and the system in vogue, should be made as public as possible.

Dr. McCormack has had exceptional opportunity of studying "rate-cutting and cheap doctors," and has taken full advantage of it. His conclusions are that "they charged less for their services because they honestly knew better than any one else did or could, that they were worth less than their competitors, and that this was their only chance to obtain and hold practice," and, he continues, "the fault is far more with the schools which pretend to educate these men than with them." It is undoubtedly true that the medical profession, by permitting the entrance through some of its portals to be disgracefully easy, attracts to its ranks many men mentally and morally incapable of appreciating the sanctity of their "calling."

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### A MODEL REPORT.

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Perhaps many have inquired in their own minds how writers of monumental works on various subjects—particularly medical subjects—managed to gather such a wealth of material and prepare it for assimilation by the average reader. Perhaps a few know, that as a rule, a large part, if not the largest part, of such material is culled from carefully compiled and accurate reports. And in proportion as the reports are faithful and scientific reflections of actual conditions, in just such proportion will our lately revised and popularly accepted standard text-books be correct.

The Fourth Annual Report of the Phipps Institute for the study, treatment and prevention of Tuberculosis is a most admirable example of an excellent report. A careful study of this

report will repay not only the medical author in search of accurate material, but will richly reward any student of medicine who is desirous of first hand information in regard to the protean phases of this many sided disease. If one is able to draw deductions from careful analyses, a wealth of practical information is contained in the 404 pages of the report.

Certain portions of the report are of special practical interest. Besides being an excellent model for future similar reports from like institutions, the clinical and sociological reports of the year by the able director, Dr. Lawrence F. Flick, contains a wealth of useful and suggestive information. After each statistical table Dr. Flick comments on his figures in a very clear and convincing manner, frequently dealing in an interesting way with debated questions. His comments on hoarseness in tuberculosis on page 71 will be appreciated by throat specialists. Another point of interest is the presence of pain in tuberculosis. Consumption is often thought of as a painless disease, and yet these statistics show that of the seven hundred and thirty-four new cases for the current year, over eighty per cent. suffered pain thus rendering it, after cough, the most frequent symptom of the disease. Still another matter of great interest which is as yet little understood, is that of disturbances of the temperature, pulse and respiration. The tables giving the results of treatment in patients with pulse above and below 100 and with respiration above and below 30, when first seen, are very instructive. A pulse rate of 100 or over and a respiratory rate of 30 or over are distinctly unfavorable prognostic signs, the latter being relatively more serious than the former according to the statistics.

The report on the blood findings in tuberculosis based on a study of 83 cases is of interest. Dr. Craig, who makes this report concludes the leucocytosis in tuberculosis can give no very definite information either in regard to the usual complications or the presence of cavity formation. The most constant finding was a chloro-anaemia present in practically all cases.

A portion of the report which is of great interest is a study by Dr. Geo. Bacon Wood on the Importance of the Upper Respiratory tract in the Etiology of Cryptogenic Infections especially in relation to Pleuritis. One result which his study shows is that of thirty-four cases of tuberculosis of the lungs studies, "the tonsils of twenty-nine showed absolutely typical lesions of tuberculosis." This study is well worth careful perusal.

Doubtless no more helpful article to the student of physical diagnosis could be found anywhere than that portion of the report dealing with the comparison of the pathological findings with the recorded clinical signs in nine cases of tuberculosis of the lungs which came to complete autopsy. This report is made by Dr. Joseph Walsh. A careful perusal of the detailed reports of each case will give one a better idea of the practical value of the ordinary signs of pulmonary conditions than can be found in any text-book.

Here one can study out for himself by this admirable check system the successes as well as the failures of the physical signs.

The entire report is of great practical value and scientific interest and should shed much light on the intricate problems of the disease with which it deals.

L. M. G.

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### PELLAGRA IN THE SOUTHERN STATES.

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The recent outbreak of Pellagra throughout the Southern States has aroused much interest and every physician should be familiar with the nature and treatment of this disease. Searcy\* in a recent article discusses in a most interesting manner the history and characteristics of this dangerous malady. He defines Pellagra (*pelle*, skin, *agra*, rough) as a condition induced by continuously eating damaged maize or Indian corn, manifested by disorders of the nervous system, derangement of the digestive system, and an erythema of the skin in certain parts of the body. Although the name is taken from the skin symptom this is regarded as the least important. Pellagra has been known in Spain since 1755, following the introduction of maize from America in about 1700.

Harris and Searcy reported the first cases that were known to have originated in the United States. The disease is quite similar to ergotism and Searcy thinks corn smut is the cause of pellagra. He gives the symptomatology as follows:

*The acute form* first shows itself in a general run-down condition, lassitude, loss of flesh, weakness, and dyspepsia. This condition may be a few weeks or months in developing. It cannot be definitely estimated, as it depends on the amount of the toxin ingested and the condition of the patient previously.

The characteristic skin lesions and those arising from the alimentary tract appear about the same time. The patient begins to have a profuse flow of saliva, the whole mouth looks red and sore, the tongue often looks denuded of epithelium, and there are digestive disturbances, tenderness over the stomach, and sooner or later, diarrhea.

About the same time there appears a deep red congestion or erythema on one or more of the exposed dorsal surfaces of the body, as the backs of the hands and lower forearms, dorsal surface of the feet, back of the neck, the cheeks, and occasionally the genitals.

The skin in these regions takes on a dark red of congested hue, with no pain and but slight burning or itching sensations; most usually it is a dead feeling, with all sensations dulled in these parts. In a few days vesicles or bullae may form, and later break and peel off, leaving a raw, weeping surface, which, if the patient survives, gradually heals, leaving a thin, silk-like skin. When vesicles and bullae do not form, the skin dries and desquamates, leaving a rough, mealy skin, which slowly smooths over.

The skin lesions are very symmetrical. When on the back of one hand or foot or cheek you will find a like patch on the other. It rarely extends more than six inches up the forearm. It sometimes is found on the elbows, and in about 10 per cent. of the cases on the genitals. I have never seen on such flexor surfaces as the palm, the bend of the elbow, axilla, or soles.

Along with the salivation, diarrhea, skin lesions, etc., come the mental and spinal symptoms, but these are not so marked in the early acute attacks, as they develop when the disease becomes chronic. Even at first, however, there is some dullness and depression noticed, very much as you find in any severe intoxication. This dullness and depression seem more marked among the insane cases than those outside the hospital.

The other nervous symptoms are pain or tenderness on both sides of the spinal column, especially in the dorsal region, and at first irregular, exaggerated patellar reflexes, but later dulled or absent reflexes. There is usually also insomnia of marked degree, and there is tenderness over the stomach, and in women pain or tenderness over the uterus.

The arterial tension is at first increased and the pulse rate a little above normal, and this goes up or down with the tempera-

ture. The temperature in uncomplicated cases rarely goes above a degree and a half above normal, and often gets subnormal. The urine often shows a higher specific gravity than normal, due probably to the fact that the patient takes very little fluid, and so there is a diminished amount of urine passed. The blood shows anaemia, but nothing characteristic.

Bacteriological examinations have proven negative, and examinations of the stools of the Mt. Vernon patients have not shown a single case of hook-worm infection.

The fatal cases may prove rapidly so in a few days from the time they take to bed, or they may run on several weeks with the salivation, diarrhea, sore hands or feet, etc., the pulse gradually getting weaker and the patient finally dying from general weakness.

When recovery follows, convalescence is very slow; the patient remains weak and more or less dull a month or more, and for several months remains below normal.

The mild cases may never go to bed, but sit about in a dull, listless manner, look weak and emaciated, with red tongue and mouth, spitting a great deal, the hands or feet or some of these dorsal surfaces showing the dry, mealy skin or the red, weeping surface, giving little or no pain or discomfort, and, lastly, with more or less diarrhea.

*The Chronic Forms.*—These cases will usually give a history of attacks during previous summers. With every attack the erythema leaves a little more pigment and thickening behind it until chronic atrophy takes place, showing where the eruption has been. The affected skin will then look wrinkled, like that of an old man. In the later attacks fewer vesicles form and the eruption is mostly of the dry, scaly type.

During the first, and even the second, year of pellagra in an individual of average intelligence no definite mental symptoms are noticed, but after that he becomes decidedly stupid and somewhat melancholic, taking little interest in anything beyond his food and sleep. As the disease progresses these mental symptoms may become more definite and there may also be hallucination and delusions of such prominence as to cause the patient to be confined in an asylum.

The usual ending of these cases showing such marked mental symptoms, and which do not respond to treatment, is in secondary dementia (Sandwith).

These chronic cases may, after they have become bedridden, develop contractures of the fingers or the lower limbs, or even paraplegia (Sandwith). They always retain control of the bladder and rectum and rarely have bedsores.

During the exacerbations of the chronic cases the red mouth and tongue may not be so pronounced as at first, but there is the weakness, emaciation, disturbance of digestion and always more or less diarrhea.

The prognosis is always grave, death occurring in more than half the cases; recovery is very slow if the patient survives.

The treatment consists chiefly in removing from the patients food all corn products and substituting a good liquid and good hygienic surroundings, but not bright sunlight. Searcy recommends arsenic in the form of atoxyl in 1 1-2 grain doses hypodermically once a week and gradually increased to 2 grains at a dose.

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#### A NATIONAL DEPARTMENT OF PUBLIC HEALTH.

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Dr. Charles A. I. Reed, of Cincinnati, in an address\* delivered before the New York Academy of Medicine makes a strong appeal for a National Department of Public Health. He discusses the various causes of the failure of Congress to pass measures heretofore submitted and shows that many of them were premature in the sense that a public sentiment was not previously too radical—most legislation being built on previous legislation is therefore evolutionary in character; other measures have failed because of a lack of medical men among our representatives. It is justly alleged that too little knowledge concerning public health has reached the people, most of it being discussed in medical societies and published in medical journals only. Reed advocates informing the public of our notable successes such as control of diseases in the Panama canal zone; the work of Finlay, Reed, Lazear and Carroll; how our health and life are being made secure by the efficient work of the Public Health and Marine-Hospital Service. He furthermore urges the importance of making more public information concerning the monetary loss from preventable diseases as tuberculosis, typhoid fever, etc.;

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\*Jour. A. M. A., November 28th, 1908.



of the importance of protecting our water sheds and of recognizing the constant menace from flies, mosquitoes, etc.

The unorganized and scattered services can be made vastly more adequate if all the national government's effort be placed in one department under one head and similar laws be passed by all states so that we may have uniformity of sanitary laws, especially those that are co-extensive with all the states—this is to be obtained through a "council of states."

"Like laws for like conditions is the first requisite for the control for any national necessity by state legislation. And like laws by the states will probably not be enacted to any great extent until, under the initiative of the national government, the states shall send delegates to a representative body, a sort of council of states, which shall meet as a legislature or as Congress meets, in a session or sessions long enough to accomplish satisfactory results, and whose object shall be to formulate standard bills on various subjects and send them back to the legislatures for enactment. In this way, and in this way alone, can the states move with anything like satisfactory rapidity in meeting the crying demand for like laws for like conditions not only in regard to great sanitary problems such as I have been discussing, but in regard to many other problems that concern the economic and social welfare of all the people. This step should be taken without delay, for, even at the best, considerable time must elapse before results from this means can be realized.

But, aside from the special proposition that we are here discussing, some such step as I have outlined is imperatively demanded to conserve the states in their present integrity."

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## NEWS AND NOTES

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Dr. and Mrs. Dunbar Roy have returned from their visit to New York.

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Dr. Ed Crawford and Miss Carol Gray were married at College Park on October 25, '08.

Dr. T. V. Hubbard had his arm broken and was otherwise painfully bruised in an automobile accident recently.

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Jonathan Hutchinson, Sen., T. R. S., F. R. C. S., was recently conferred to honor of Knight by King Edward.

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Cincinnati University is to have a new building for the College of Medical Sciences to cost \$275,000, besides \$25,000 for equipments.

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Cooper Medical College, San Francisco, began its career as an integral part of Leland Stanford, Jr., University, November 3. It will henceforth be known as the school of medicine of the university.

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The marriage of Dr. J. Edgar Paulin and Miss Edna Frederic of Marshallville, Ga., will be an event of wide interest.

Though Dr. Paulin has made his home in Atlanta only recently, he is proving himself as welcome professionally as his charming bride will be socially.

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The doctors of the Third Congressional District held their fourth annual meeting at Montezuma, Ga., on Wednesday, Nov. 18, about twenty-five physicians were in attendance and several interesting papers were read. Americus was chosen as their next meeting place.

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The Southern Medical Association holding their annual convention here were beautifully entertained by the physicians of Atlanta at a reception at the Piedmont Driving Club.

The guests were received by Dr. Willis Westmoreland, chairman of the reception committee, and a large number of Atlanta's most prominent men and women.

John A. Taff, an osteopath of Boston, formerly of Louisville, Ky., charged with practicing medicine without being registered as a physician, was sentenced to imprisonment for three months in the House of Correction.

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At the recent celebration of "Academic Day" of the University of Maryland, it was decided to erect a tablet in memory of the late Major James Carroll, of the Army Medical Corps, who received his diploma from this University.

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Students of the senior class of the Medical Department of the University of Buffalo, presented Dr. Roswell Park with a silver service in honor of his completion of a quarter of a century as professor of surgery in the institution.

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Regarding the North Carolina leper, who is now in Washington, D. C., Secretary Cortelyou has recently issued a statement in which he asserts that while he has authority to make regulations to prevent the introduction of contagious or infectious diseases into a state or territory or the District of Columbia, he has no authority to make a rule whereby this leper can be deported from Washington, or whereby North Carolina can be required to receive him.

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The directors of the North Carolina State Hospital, Morganton, at a recent meeting, entered a formal protest against the recent action of the State Hospital Commission in declining to add to the existing plant of the State Hospital for the Insane. Morganton, until the State Hospital for the Insane at Raleigh had been enlarged and made to accommodate as many as the former institution; and furthermore, in ordering all tuberculosis cases in the Raleigh institution to be conveyed to the Morganton institution, which is situated in the mountains.

Two gold medals, which are given every three years by the International Conference on Tuberculosis for work done in advancing the fight against tuberculosis, have been awarded to Mr. Henry Phipps, of New York, and Dr. Frederick Althoff, of Berlin.

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By a resolution of the Berlin Council it is directed that in the coming winter 8,000 poor school children shall receive warm dinners in the soup kitchens. The same privilege is to be extended to children not of school age on the recommendation of charitable societies.

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The Supreme Court of Georgia had just decided that when an employer summons a physician to care for an employee who has become suddenly ill, the employer is not liable for the bill unless there is a definite agreement between the employer and employee that the former shall be liable.

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The United States Civil Service Commission announces an examination on January 13, 1909, at the regular locations throughout the United States, for a medical interne (female) in the Government Hospital for the Insane, Washington, at \$600 a year, with maintenance.

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The members of the Association of Military Surgeons of the United States were shown many social attentions while holding their seventeenth annual meeting in Atlanta.

On their first afternoon in the city, the visiting delegates were taken for an automobile ride, the next, as guests of the State Fair Association. They had all the privileges of the fair extended to them, scattering about the grounds at the Piedmont Park, and occupying boxes at the races.

The Fulton Medical Society gave a brilliant reception at the Piedmont Driving Club in honor of the visiting Surgeons to which two hundred and fifty guests were invited. The entire

house was artistically decorated, and music in the ballroom added to the enjoyment of the occasion.

The guests were received by Dr. Willis Westmoreland, chair-ceiving party including Dr. and Mrs. Bates Block, Dr. and Mrs. E. C. Davis, Dr. and Mrs. Hugh Lokey, and Dr. and Mrs. Lindorm. A buffet supper was served at ten o'clock.

A barbecue at Morgan's 'cue grounds given by the Local Military Organization was the concluding social feature and was very much enjoyed.

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At the annual meeting of the Sixth District Medical Association, held in Macon November 11, Dr. Alfred F. White, Flovilla, was elected president; Dr. James W. Cowart, Walden, vice-president, and Dr. Eugene B. Elder, Macon, secretary-treasurer (re-elected). The next meeting will be held at Indian Springs.

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## SELECTIONS *and* ABSTRACTS

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### FREMONT COUNTY (WYOMING) MEDICAL ASSOCIATION—RESOLUTION ON DEAD-BEATS.

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The officers and members of the Fremont County Medical Association, being in regular session, deeming it wise to take action in regard to persons who are "Dead-Beats" and others who are slow pay, in order to receive compensation for their services and to discourage the public from employing one physician while already indebted to another who is a member of this association, and

Whereas, The members of this association have suffered in the past from wilful neglect of those who are able, but unwilling to pay for the services rendered by physicians,

And whereas, Certain persons have patronized one physician as long as credit was extended, and then changed to another, and so on, as long as another was to be had, or credit could be obtained.

And whereas, In order to ingratiate themselves into the good graces and confidence of the physician subsequently called, they

have resorted to false promises and villification of other members of the profession,

And whereas, The members of the profession have been put to a great deal of expense, as livery hire, cost of drugs, surgical dressings, etc., and have been humiliated by the ingratitude and discourtesy of said persons, by misrepresentation and calumny,

And whereas, Such conditions are likely to lead to discord and misunderstanding between members of this association, therefore,

Be it resolved, That the members of this association be instructed to present the names of such persons to the secretary, who shall read them at the next regular meeting, and furnish each member with a copy of the same,

And be it Resolved, That for reasons already set forth, every member of this association, shall refuse to extend any credit or services whatever, to such person or persons, or his or her family but upon being called, shall demand his fees in advance, and continue to do so until said person shall have made satisfactory settlement with the physician to whom he or she is indebted and his or her name withdrawn from the list.

And Be it Further Resolved, That when legal measures are instituted for the collection of such accounts against such person or persons, by any member of this association, each and every member of same shall render all aid possible in prosecution of such suit, and the collection of the same,

Further, That violations of these tenets shall be reported to the censors who shall investigate the same, and if found worthy, prefer charges.

Further, That such list shall be known as the "Black List," and that this resolution be spread upon the minutes of this meeting, and that a copy be sent to every member of this association.  
—*Western Medical Review.*

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#### THE FIRST OPERATION FOR APPENDICITIS.

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The question is often asked, "When was the first operation for appendicitis performed?" We have been asked it this week almost exactly in these words. The answer must depend greatly on what is meant by operations for appendicitis. If we may include among such operations the evacuation of an abscess resulting from an attack of appendicitis we must go back a very long

way indeed. Doubtless many such abscesses were opened ages before any record of such an operation was made. Aretaeus, who flourished some 50 years before the commencement of the Christian era, says: "I once made an incision into an abscess in the colon on the right side near the liver and much pus gushed out." This may have been an appendix abscess, but he goes on to say that much pus was evacuated also with the urine, so that we cannot be sure that it was not a pyonephrosis. Here and there through the following centuries we find cases recorded which are fairly certainly examples of incision of an appendix abscess, but it was not until 1759 that we meet with an operation for abscess which was definitely shown to be due to disease of the vermiform appendix; in that year Mestivier incised an abscess on the right side of the abdomen near the umbilicus and much pus was evacuated. The wound healed but the patient died before long and at the necropsy a pin was found in the appendix with many signs of inflammation. Seven years later Lamotte described a large foecal concretion in the appendix, but the discovery was only made post mortem. In 1848 Hancock reported the opening of an abscess immediately above Poupart's ligament on the right side and later two foecal concretions came away. The incision was made early, even before fluctuation could be detected. In 1867 Parker published four similar cases and from that time the opening of abscess in the right iliac fossa became less rare. The earliest suggestion to remove the appendix appears to have been made by Fenwick in 1884, and this operation was performed by Kronlein in the same year. He opened the abdomen of a boy aged 17 years who had general peritonitis and ligatured and removed the perforated appendix. Some temporary improvement followed, but death occurred three days after the operation. Symonds, in 1885, removed a concretion from an appendix without opening the peritoneal cavity. The first successful operation for removing the appendix was performed by Morton in 1887 and from that time the operation has become common. We have then answered the question, "When was the first operation for appendicitis performed?" by showing that appendix abscesses have been opened many centuries ago; that Hancock, in 1848, incised an appendix abscess before fluctuation could be felt; that Kronlein, in 1884, removed a perforated appendix but the patient died; and that Morton, in 1887, had the first successful case of appendicetomy.—*Lancet*.

## BOOKS RECEIVED

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**COLORADO SOUVENIR BOOK** for the International Congress on Tuberculosis. Published by the Colorado State Organization.

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**PRACTICAL POINTS IN ANESTHESIA.** By Frederick-Emile Neef, B. S., B. L., M. D., New York City, Surgery Publishing Co., New York.

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**PARAFFIN IN HERNIA.** By Charles G. Miller, M. D., Comprising a description of the treatment of Hernia by paraffin injections. Published by the author, 70 State street, Chicago. Prepaid, \$1.00.

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**THE PROCTOLOGIST.** A quarterly journal devoted exclusively to rectal diseases, edited by Rollin H. Barnes, M. D., St. Louis. This volume contains the Transactions of the American Proctologic Society, 1908.

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**A HANDBOOK OF SUGGESTIVE THERAPEUTICS.—** Applied Hypnotism, Psychic Science. By Henry S. Monroe, Americus, Georgia. Second Edition. C. V. Mosby Medical Book and Publishing Co., St. Louis, Mo.

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**LECTURES ON THE PRINCIPLES OF SURGERY.** By Stuart McGuire, M. D., Professor of Principles of Surgery and Clinical Surgery, University College of Medicine, Richmond, Va. Published by Southern Medical Publishing Co., Baltimore, Md.

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**A TEXT BOOK OF HUMAN PHYSIOLOGY, THEORETICAL AND PRACTICAL.** By George V. N. Dearborn, A. M. (Harvard), Ph. D., M. D., (Col.) Professor of Physiology in the Medical and Dental Schools of Tufts College, Boston, Professor of the Relations of the Body and Mind in the Sargent School for Physical Education in Cambridge, etc.; Illustrated with 300 Engravings and 9 plates. Lea & Febiger, Philadelphia.



**DISEASES OF THE SKIN.** By A. H. Ohmann-Dumesnil, A. M., M. E., M. D., Ph. D., etc.; Formerly Professor of Dermatology and Syphilology in the St. Louis College for Medical Practitioners; the St. Louis College of Physicians and Surgeons, etc. Third edition thoroughly revised and enlarged, 140 original illustrations. C. V. Mosby Medical Book and Publishing Co., St. Louis, Mo.

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**DISEASES OF THE SKIN AND THE ERUPTIVE FEVERS.** By Jay Frank Schamberg, M. D., Professor of Dermatology and Infectious Eruptive Diseases in the Philadelphia Polyclinic and College for Graduates in Medicine. Octavo of 534 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1908. Cloth, \$3.00 net. W. B. Saunders Company, Philadelphia and London.

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**A MANUAL OF DISEASES OF THE NOSE AND THROAT.** By Cornelius Godfrey Coakley, A. M., M. D., Professor Laryngology in the Bellevue Hospital Medical College, New York City; Laryngologist to Columbus Hospital, the University and Bellvue Hospital Medical College Clinic, etc. Fourth edition, revised and enlarged, Illustrated with 126 engravings and 7 colored plates. Lea & Febiger, Philadelphia.

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**GENERAL SURGERY.** A Presentation of the Scientific Principles upon which the practice of modern surgery is based. By Ehrich Lexer, M. D., Professor of Surgery, University of Konigsberg. American Edition, Edited by Arthur Dean Beaver, M. D., Professor and Head of the Department of Surgery, Rush Medical College in Affiliation with the University of Chicago. An Authorized Translation of the Second German Edition, by Dean Lewis, M. D., Assistant Professor of Surgery, Rush Medical College in Affiliation with the University of Chicago. 449 illustrations in the text, partly in color, and two colored plates. 8vo. pp. xxix., 1041. New York and London: D. Appleton and Co., 1908.

## BOOK REVIEWS

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**GYNECOLOGY AND ABDOMINAL SURGERY.** In two large octavos. Edited by Howard A. Kelly, M. D., Professor of Gynecologic Surgery at Johns Hopkins University; and Charles P. Noble, M. D., Clinical Professor of Gynecology at the Woman's Medical College, Philadelphia. Large octavo volume of 862 pages, with 475 original illustrations by Mr. Hermann Becker and Mr. Max Brodel. Philadelphia and London: W. B. Sanders Company, 1908. Per volume: Cloth, \$8.00 net; Half Morocco, \$9.50 net. W. B. Sanders Company, Philadelphia and London.

The first volume of this splendid work was reviewed sometime ago in our pages and it is again our privilege and pleasure to commend it in the highest possible manner, both as to subject matter and also as regards the excellent illustrations and the high-class of book-making which it so well exemplifies. The limited space forbids a detailed mention of the various subjects covered by the well known surgeons who contributed to this volume; the mere mention of their names is sufficient guarantee of the quality of their contribution, each having taken special interest for years in the subjects discussed. It is with particular pleasure that we note the name of our able and esteemed collaborator Dr. Floyd W. McRae among the authors of Volume II. The full list of authors is as follows:

Brook M. Anspach, M. D.; Joseph C. Bloodgood, B. S., M. D.; John M. T. Finny, A. B., M. D.; Barton Cooke Hirst, A. B., M. D.; Guy L. Hunner, B. S., M. D.; Elizabeth Hurdon, M. D.; George Ben Johnston, M. D.; Howard A. Kelly, A. B., M. D., L.L. D.; F. R. C. S. Hon. Edwin; Edward Martin, A. M., M. D.; Floyd W. McRae, M. D.; G. Brown Miller, B. S., M. D.; B. G. A. Moynihan, M. S., F. R. C. S.; Pohn B. Murphy, A. M., M. D. D. C. L., England, L.L. D.; Charles P. Noble, M.D.S.D.; Richard C. Morris, A. M., M. D.; Albert J. Ochsner, B. S., F. R. M. S., M. D.; Eugene L. Opie, M. D.; J. F. W. Ross, M. D.; Stephen H. Watts, A. M., M. D.; J. Whittridge Williams, A. B., M. D.; S. D.

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**PRINCIPLES OF SURGERY.** By Stuart McGuire, M. D., Professor of Principles of Surgery and Clinical Surgery,

University College of Medicine, Richmond, Va. Published by Southern Medical Publishing Co., Baltimore, Md..

The wide experience of Dr. McGuire which he has acquired, added to the natural tendency towards surgery, which he inherited from his distinguished father, makes him peculiarly qualified as a surgeon, while his extensive experience as a teacher have shown him what the student needs. In the above lectures McGuire gives modern views of the principles of surgery in a clear, concise manner that will undoubtedly prove of value to the student and practitioner. The book comprises 480 pages of text from a surgeon; while his extensive experience as a teacher have shown which may be readily obtained a good working knowledge of surgery.

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DISEASES OF THE NOSE AND THROAT. By C. G. Coakley, A. M., M. D.; 4th edition pp. 604. Published by Lea & Febiger.

The new edition of this manual has been brought up to date. The more recent operations, such as submucous resection of the septum are sufficiently described, and a valuable chapter on therapeutics has been added. The book is worthy of the enviable reputation of its author, and may with confidence be recommended to such as desire a safe guide without unnecessary detail. We have observed, however, not a few printer's errors which somewhat mar the total excellence of the work; for example, on page 120 pulmilionis for pumilions; page 246, figure 52 is not Gruenwald's forceps; page 336, Eucalyptol  $\text{℥ss}$  should doubtedly be  $\text{℥ss}$ . Then we greatly doubt the wisdom of prescribing cocain in hay fever, even with a warning against the danger of becoming habituated to its use, because patients who have once used cocain for any length of time are thereby rendered less susceptible to further improvement by other means. What do the following sentences (page 209) mean? "If pus is seen between the middle turbinate and the septum it is an evidence that either the artrum frontal sinus, or anterior group of eth-modal cells, or some combination of these is involved. If secretion is seen between the middle turbinate and the septum, this indicates involvement of the posterior eth-moidal cells of sphenoidal sinus or both together."

A. W. S.

**ARTERIOSCLEROSIS.** Etiology, Pathology, Diagnosis Prognosis and Treatment. By Louis M. Warfield, A. B., M. D., instructor in medicine, Washington University, Medical Department; Physician to the Protestant Hospital, Adjunct Attending Physician to the Martha Parson's Hospital for Children, St. Louis, Mo., etc. With introduction by W. S. Thayer, M. D., Professor of Clinical Medicine, Johns Hopkins University. Eight original illustrations. Published by C. V. Mosby Medical Book Co., St. Louis, Mo.

Warfield has summarized the recent ideas and results obtained from experimental research and from clinical observation of arteriosclerosis, and has presented a readable and authoritative monograph which will be of undoubted value to the general practitioner. Stress is appropriately laid on the prevention of arterioclerosis rather than on the treatment of the fully developed disease.

Thayer, in the introduction, urges that care be exercised in making a diagnosis of arterioclerosis and that it should not be used as a cloak for carelessness of ignorance. We heartily commend the work to all of our readers interested in this subject.

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**THE PRACTITIONERS' VISITING LIST FOR 1909.** An invaluable pocket-sized book containing memoranda and data important for every physician, and ruled blanks for recording every detail of practice. The Weekly, Monthly and 30-Patient Perpetual contains 32 pages of data and 160 pages of classified blanks. The 60-Patient Perpetual consists of 256 pages of blanks alone. Each in one wallet-shaped book, bound in flexible leather, with flap and pocket, pencil and rubber, and calendar for two years. Price by mail, postpaid, to any address, \$1.25. Thumb-letter index, 25 cents extra. Descriptive circular showing the several styles sent on request. Lea & Febiger, publishers, Philadelphia and New York.

Being in its twenty-fifth year of issue. The Practitioners' Visiting List embodies the results of long experience and study devoted to its development and perfection.

It is issued in four styles to meet the requirements of every practitioner: "Weekly," dated for 30 patients; "Monthly," undated for 120 patients per month; "Perpetual," undated, for 30 patients weekly per year, and "60 Patients," undated, for 60 patients weekly per year.

The text portion of The Practitioners' Visiting List for 1909 has been thoroughly revised and brought up-to-date. It contains among other valuable information a scheme of dentition; tables of weights and measures and comparative scales; instructions for examining the urine; diagnostic table of eruptive fevers; incompatibles, poisons and antidotes; directions for effecting artificial respiration; extensive table of doses; an alphabetical table of diseases and their remedies, and directions for ligation of arteries. The record portion contains ruled blanks of various kinds, adopted for noting all details of practice and professional business.

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**PRACTICAL POINTS IN ANESTHESIA.** By Frederick-Emil Neef, B. S., B. L., M. L., M. D., New York. Price Semi-De Luxe-Cloth 60 cents, post paid. Library. De Luxe Flexible leather \$1.50 post paid.  
Surgery Publishing Co., 92 William St., N. Y. U. S. A. .

This very practical monograph presents the author's impressions on the correct use of chloroform, ether, etc., and is a simple and coherent working method, and is of particular value to those general practitioners who are so situated that the services of a trained anaesthetist cannot be secured. Among the subjects covered are: Induction of Anaesthesia, Cardiac and Respiratory Collapse, When shall the Patient be Declared Ready for Operation, Maintenance of the Surgical Plane of Anaesthesia, Important Reflexes, Vomiting during Anaesthesia, Obstructed Breathing, Use of the Breathing Tube, Indications for Stimulation, Influence of Morphine on Narcosis, General Course of Anaesthesia, Awakening, Recession of Tongue after Narcosis, Post-Operative Distress, Minor Anaesthesia with Ethyl Chloride, Intubation Anaesthesia, etc.

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**A TREATISE ON THE PRINCIPLES AND PRACTICE OF GYNECOLOGY.** By E. C. Dudley, A. M., M. D., Professor of Gynecology in the Northwestern University Medical School, Chicago. Fifth edition, thoroughly revised.

Octavo, 806 pages, with 431 illustrations, of which 75 are in colors, and 20 full-page colored plates. Cloth, \$5.00, net; leather, \$6.00 net; half-morocco, \$6.50. Lea & Febiger, publishers, Philadelphia and New York, 1908.

This is the fifth edition of Prof. Dudley's Gynecology within the last ten years. The advantage of presenting this subject according to cause rather than by regions becomes apparent when reading the work of Dudley, who was the first to present gynecology in this manner. The book met with a most cordial reception and, justly so, in its early editions and since then has increased in favor, as well as in excellence by the addition of numerous and illuminating illustrations. It is with pleasure we recommend most highly this book as one of the best of its class. The new edition has been thoroughly revised to date and much new matter and many new illustrations added.

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## MEDICAL ITEMS

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As the cold damp winds of fall chill the skin, more of the work of elimination is thrown upon the kidneys. It is not always the function of the kidney can be adjusted to this increased demand, and imperfect elimination of waste products results.

This autotoxic state gives rise to such conditions as rheumatism, tonsillitis, neuralgia, catarrhal bronchitis, with or without asthma, winter eczema and pruritis, catarrhal rhinitis, and many other less distinctly defined conditions.

The best results in treatment are to be had from establishing thorough renal elimination. Nothing accomplishes this so promptly and so effectually as Alkalithia in teaspoonful doses, in half a glass of water, every four hours, and a cure follows the removal of the cause.

---

It is generally conceded that cod liver oil is to be considered more as food than as medicine. Potter says: "Cod liver oil is the most easily digestible of fats, penetrating animal membranes with comparative ease, hence entering the lacteal vessels readily and

appearing to carry with it the oily and nitrogenous elements of the food."

But every physician understands the uses of cod liver oil, what concerns him most is, to have it in such form that his patient will take it and enjoy taking it, for after all, it is the continued use and assimilation of this valuable nutrient that brings the best results.

The physician reader will be glad to know that there is now within range of his prescription pad, an emulsion of cod liver oil, that a prominent physician characterizes as follows: "One of the most elegant preparations of modern pharmacy in EMULSION OLEI MORRHUAE (Cloftlin). Don't make the mistake of looking on this as only one more emulsion, but investigate its unique merits."

We are quite sure, that nothing would please its manufacturers better than to have every physician reader of this Journal make use of their prerogative, to investigate by careful clinical test, the good qualities of EMULSION CLOFTLIN. We are informed that liberal samples and full descriptive matter will be sent express prepaid, to all registered physicians, who will send their name and express office address to The Cloftlin Chemical Co., 75-77 Cliff street, New York.

*The Cloftlin Chemical Co., 75 Cliff street, City:*

Gentlemen: At your request, we purchased a package of the medicinal preparation called Emulsion Cloftlin, at a pharmacy on Broadway, in this City, and, upon careful analysis of the same, we find it contains the following medicinal ingredients in the quantities below stated; to-wit:

Cod Liver Oil, by weight, 51.05 per cent.

Glycerine, by weight, 14.41 per cent.

Calcium Hypophosphite, by weight, 1.57 per cent—7 grains per fluid oz.

Manganese Hypophosphite, by weight, 0.66 per cent.—3 grains per fluid oz.

This is equivalent, in the case of the cod liver oil, to fully 50 per cent. by volume, and of the glycerine, 10 per cent.

Very truly yours,

LEDERLE LABORATORIES.

October 27, 1906.

CASE NOTES ON HYOSCINE, MORPHINE AND CACTIN—H. M. C. COMP.

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C. W. HUNT, M. D., BREVARD, N. C.

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Fractured leg, very painful, hypodermic injection of one tablet, repeated the dose in one hour, the effect was perfect. I gave all necessary treatment, left the patient sleeping soundly.

In obstetrical cases, either in true labor or in "false alarms." I always give a tablet immediately. I find it the best treatment for threatened abortion and premature labor or false alarms. In true labor if lingering and slow, it gives both physician and patient rest. It has relieved all the first pains of labor, the cutting and nagging pains, those mostly complained of by the patient.

If labor is active and the first dose is given at once, it prepares the way, and makes time for a second dose. The second dose should not be given sooner than one hour after the first and then, a half tablet only may be given as the dose. When a sufficient length of time has not elapsed for a second dose of tablets, and if labor is nearly finished and pain severe or even uncomfortable, I give a few drops of chloroform. (I would beg to state here that I believe in relieving all of the pain of labor and all of the after-pains.) I administer a whole tablet by placing it under the tongue and allow it to be absorbed. If not so quick as a hypodermic injection, the effect is more lasting and is better suited.

For an obstetrical case when a dose is given at the commencement of labor; if a quicker effect was desired, when labor is well advanced, one by hypodermic injection would be best. I find that one tablet first and then followed by chloroform in from two to four or six drops, for each contraction as needed, gives perfect results.

The respiration and pulse may be first noticeable affected by one tablet. I have not noticed any effect upon the baby.

I have used the H-M-C tablet for various conditions for one year and I think they are all that is claimed for them by the Alkaloidal Company. All we need is more practice in their use and we should never forget their power and become careless in their use.

Mrs. D. Severe "false labor" pains, one month before the time of confinement. H-M-C tablets gave satisfaction.



JOURNAL-RECORD OF MEDICINE.

June 19th. Mrs. S., primipara, first stage, gave her a tablet, at 2:30 a. m. The patient was easy and slept till 6 a. m. (Am glad to say that the doctor also slept a bit.) Six a. m. os well dilated; a few drops of chloroform were given at each pain; (only a fraction of as much as used on the many other occasions when no tablet was given;) painless delivery at 7 a. m.

Mrs. D. Fourth labor. June 23rd, 4:30 a. m. first stage dilation of cervix scarcely commenced, rigid os, subsequent dilation very slow, for which manipulation and Abbott's treatment for rigid os given with perfect results. First tablet given. The patient was heavily influenced at the end of the first hour. This continued for three hours and the control of pain continued for the next three hours, making six hours, in the third three hours of the twelve hour period, the effect was good but a little lighter, the last three hours of the twelve hour period at 4:30 p. m. though patient was sleepy, sleeping some during some of the contractions without aid of chloroform, yet some of the contractions required from two to six drops of chloroform, when we take this into account the loss by evaporation, the loss of chloroform by an account of patient's failure to inhale promptly, we realize how little chloroform that the patient actually received.

Fewer drops were required during the first, second and third three hour sections of the twelve hour period, more required during last quarter of the twelve hours, say about six drops, contraction also growing stronger as labor advanced. At 8 p. m. the second tablet was given. The bag of waters ruptured at 11:45 p. m.; baby born 12:45 a. m.; not affected by tablets; full of life and crying.

The 8 p. m. tablet gave profound sleep in forty-five to sixty minutes. Relief was nearly completed till eleven o'clock and a few drops of chloroform only given every fourth or fifth contraction, 11:30 to 12:45 influence of tablets exhausted. In looking over this case, I now believe that if the second tablets had been given by hypodermic injection, it would have given quicker relief, lasting long enough to cover the remaining labor.

Mrs. H., 12th confinement. June 25th. (In this case no chloroform was given.) The head under pubic arch. Tablet given under tongue 10:30. 10:55 delivery. Pain much lessened and after pains, for which the patient is famous, were prevented till 7 p. m. Had I not been pressed for time, this tablet should

**The purest, freshest cod-liver oil  
that money can buy, emulsified by  
a process that facilitates its diges-  
tion in a marked degree and en-  
hances its palatability and stability,  
are the distinctive features of**

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**Sample with literature mailed to any physician on request**

have been given hypodermically, for a quicker effect if not so lasting. While the patient felt some pain, she was well satisfied with the effect of the tablet. I had in former labors given her chloroform and she knew how labor pains could and should be relieved.

June 26th. Mrs. L., a little over 16 years of age. First labor. Well advanced, head starting under pubic arch. I immediately gave tablet 3:35 p. m. The continuous pains between regular contraction relieved and pain of height of contraction was greatly soothed. By 4:20 head descending and contraction much more severe, patient quite soothed and states that the pains were easier then before I came, while all of the pain was not relieved—the effect was wonderful and pleasing. At 4:45 commenced giving a little chloroform, and account of rigid perineum a very small amount used, effect greatly enhanced by preceding tablet, painless delivery at 5:50, baby all O. K. Placenta removed, and then the mother was awakened.

Mrs. L. July 5th. Slow pains, dry labor, head high up, cervix slightly dilated, pains regular, though short, patient nervous, very sensitive to pains. No chloroform used. 4 a. m. gave one tablet under the tongue. This soon relieved seemingly three-quarters of the pain. The patient cried out a little during the height of pain. She slept nicely during pains. For one hour a soothed state increased. The patient did not notice the pain from the commencing and ending of a contraction, only moaned during acme of pain. At five and six a. m. I gave half a tablet, this intensified the hypnotic condition, and patient only moaned slightly, though she was awake and conscious during much of the pain, the head becoming more engaged and pains more severe. The baby was born at 10:00 a. m. At nine the head descended under the pubic arch and pressed the vaginal floor. Pains more severe and effect of medicine seems to be decreasing which allowed the patient to suffer more, though her greatest pain was light and well borne, sleeping soundly between all pains and during a greater part of each pain, and went to sleep after the baby was born. I considered this quite a victory for the tablets, as I make it a practice if possible to relieve *all* of the pain of labor, allowing the patient to be barely unconscious. I have formulated the following rule for my painless obstetrical cases to get a perfect relief from all pain, I consider that too much of the H-M-C tablet would be required, i. e.—that the system would be too profoundly affected between pains, by a sufficient amount of H-M-C given to relieve all pain and cause sleep at the acme of each pain, I therefore have formulated the following rule:

I give one tablet at once, and if necessary a half tablet every hour, then if pain is not sufficiently relieved, to supplement the effect of H-M-C by a fractional amount of chloroform, this can be given or not, as the case requires at every pain, or only occasionally, whereas if an additional amount of H-M-C is given, we get a continuously increased effect at the time of, and between the pains, whereas the supplemental chloroform's action is only temporary and can be withdrawn or withheld at pleasure. Besides one might not be certain whether labor pains will be regular. The contraction may cease without any reason, in such cases too much of the H-M-C or chloroform would be dangerous.

In surgical work, the surgeon should take the increased time demanded by anaesthesia, with H-M-C and give his patient the

# Peacock's Bromides

## The BEST FORM of BROMIDES

Each fluid drachm contains fifteen grains of the neutral and pure bromides of Potassium, Sodium, Ammonium, Calcium and Lithium.

In Epilepsy and all cases demanding continued bromide treatment, its purity, uniformity and definite therapeutic action insures the maximum bromide results with the minimum danger of bromism or nausea.

DOSE—One to three teaspoonfuls according to the amount of Bromides desired. Put up in half pound bottles only. Free samples to the profession upon request.

Peacock Chemical Co., St. Louis, Mo.  
Pharmaceutical Chemists.

# CHIONIA

## The HEPATIC STIMULANT

Prepared from Chionanthus Virginica Expressly for Physicians' Prescriptions

Chionia is a gentle but certain stimulant to the hepatic functions and overcomes suppressed biliary secretions.

It is particularly indicated in the treatment of Biliousness, Jaundice, Constipation and all conditions caused by hepatic torpor.

DOSE—One to two teaspoonfuls three times a day. Put up in half pound bottles only.

Free samples to Physicians upon request

Peacock Chemical Co., St. Louis, Mo.  
Pharmaceutical Chemists.

# PRUNOIDS

## AN IDEAL PURGATIVE MINUS CATHARTIC INIQUITIES

A scientific and delightful remedy for permanent removal of constipation.

PRUNOIDS ARE MADE OF PHENOLPHTHALEIN (ONE AND ONE-HALF GRAINS IN EACH), CASCARA SAGRADA, DE-EMETINIZED IPECAC AND PRUNES.

DOSE—ONE TO THREE PRUNOIDS  
SOLD IN SEALED BOXES (36 PRUNOIDS) 50 CENTS  
WHOLESALE AND RETAIL DRUGGISTS

# SENG

## A SECERNENT TO TONE THE FUNCTIONS OF DIGESTION

For indigestion, malassimilation, malnutrition; to restore the functional activity of the secretory glands.

A PLEASANT PREPARATION OF PANAX (GINSENG)  
IN AROMATICS

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For functional heart troubles. Is not cumulative in its action. An excellent remedy in tachycardia, following the excessive use of tobacco, tea, coffee or alcoholics.

DOSE—ONE TO THREE PILLETS, AS INDICATED

EACH PILLET CONTAINS ONE ONE-HUNDREDTH OF  
A GRAIN OF CACTINA, FROM CEREUS GRANDIFLORUS.

SOLD IN BOTTLES OF 100 PILLETS—50 CENTS  
WHOLESALE AND RETAIL DRUGGISTS

In prescribing the above elegant pharmaceuticals, always see that the genuine is dispensed. Samples to physicians. Advertised only to the medical profession, and manufactured exclusively in the laboratories of

SULTAN DRUG COMPANY, Pharmaceutical Chemists, SAINT LOUIS, MO.

benefit of this cheaper, safer and improved method. In surgery the pain is not so uncertain, irregular and intermittent as in obstetrical cases, the full dose can be given and measured, to a much more regular and uniform pain. The surgeon could allow a professional nurse to administer the first hypodermic, but he should take time and examine the patient and administer the second personally, and then take time to get the effect of the medicine before operating.

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### GLYCO-THYMOLINE AS A THERAPEUTIC AGENT IN TREATMENT OF NASAL CATARRH.

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BY ERLE B. WOODWARD, M. D., LINCOLN, NEB.

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I am becoming more and more of the opinion that the doctor ought to know his therapeutic agents and his patients so thoroughly that he can say with accuracy just what the result of any therapeutic measure will be. In this paper I shall report what Glyco-Thymoline did and did not do for me.

These cases are not selected cases, in any other sense than that they were typical of various forms seen in everyday practice. I made a special endeavor to determine just how much Glyco-Thymoline can be expected to do.

Case I.—Acute Septic Rhinitis.—I have reports of several cases of this kind treated with Glyco-Thymoline with gratifying results. One especially was that of Miss L. D., fibrinous rhinitis, school girl, aged 12. Had what was called a cold in the head for one week; upper lip was excoriated, nose absolutely blocked with white membrane very like that found in the throat of a diphtheria patient. It all came away readily without bleeding. I cauterized whole surface with a solution of silver nitrate, 40 grains to the ounce. Gave her a K. & O. Nasal Douche and Glyco-Thymoline and sent her home with directions to cleanse the nose every hour. She reported next day as fine as you please. I confess I was a little surprised at the rapid cure.

Case II.—Simple Chronic Rhinitis, Pharyngitis and Laryngitis.—Mr. F., of Lincoln, professional singer. Patient applied for treatment November 23, 1900, because of a thickness of speech. Nasal respiration very difficult. Interior turbinates were very much swollen (not hypertrophied) so much so that one or the

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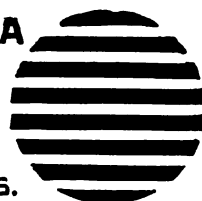


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other pressed upon the septum all the time. Peculiar sense of obstruction about throat, especially when attempts were made to swallow. There was a rather free secretion of mucus, which necessitated free use of handkerchief, together with considerable hawking and spitting. This condition had gradually developed in past eight or ten years. To determine what Glyco-Thymoline would do absolutely unaided I had him use it as douche and gargle three times a day and gave as nearly perfect rest to the voice as possible. At the end of two weeks he reported the turbinates very much reduced, free nasal respiration established; very little discharge; was so comfortable that he did not feel a need for further treatment, but as the vocal cords and larynx were still somewhat catarrhal I made local applications of zinc chloride, 10 grains to the ounce. At the end of two weeks this produced a perfect result. He is to continue using Glyco-Thymoline daily for a while.

---

H. V. C.

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## POST HEMORRHAGIC ANEMIA.

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The anemia which follows the hemorrhages of trauma, gastric or intestinal ulcers, severe epistaxis, child birth, profuse menstruation or hemorrhoids presents a clinical picture that is so well-known that it requires no description.

Examination of the blood immediately after a severe hemorrhage usually shows no apparent change in its number of corpuscles, for the portion lost withdrew the blood as a whole, and the portion remaining in the body, while decreased in volume, will be found to contain a normal ratio of fluid and cells. Shortly after a hemorrhage, however, the tissues of the body give up large quantities of fluid to restore the necessary volume of the blood and a condition of true hydremia ensues. Examination of the blood three or four hours after a severe hemorrhage, therefore, shows a very marked oligocythemia. Reconstruction must now take place and the response to the bodily demand is sometimes remarkably prompt, but in most instances it is a hard up-hill fight. This is to be expected, for the disproportion between the cells and the fluid elements of the blood, and the essential depression of all vital functions, makes recuperation a difficult process at best.

Much can be done, however, to assist the body in its efforts to restore normal conditions. The first and most essential requirement is absolute rest in a prone position. In some instances, it may be necessary for a few days to have the couch or bed tilted so that the patient's head shall be lower than the feet. Sudden movements or sudden rising to an upright posture must be strictly interdicted as these are always liable to produce a fatal syncope. Following severe hemorrhage, the blood pressure is always lowered, and even if a certain degree of tension is apparently restored, it is very unstable, and may be lost instantly with all of the resulting dangers on the heart and central nervous system.

Another precaution to be taken is to frequently change the patient's posture from one side to the other. The hydremic state of the blood, and the loss of blood tension predisposes to gravitation oedema in the lungs and other organs, and the simple procedure of changing the patient's position often avoids annoying and serious complications.

Tonsillitis  
Bronchitis

Abscesses  
Boils

INFLAMMATION'S ANTIDOTE



APPLY HOT AND THICK

Ulcers  
Erysipelas

Synovitis  
Lymphangitis

Considerable quantities of water are always necessary after hemorrhage, but it should never be given in large amounts at any one time. Two or three tablespoonsful at a time by the mouth every few minutes is much more beneficial than to allow a patient to drink to satiation. Excessive thirst is always soon controlled by small enemas (one pint) of saline solution, as warm as can be borne, repeated every three or four hours. These also serve admirably to very materially raise arterial tension. It is no uncommon thing to observe complete anuria for even twenty-four hours after severe hemorrhages, but the warm saline enemas soon correct this condition.

Feeding is one of the most important details in post-hemorrhagic treatment. Liquid food should be used in preference to solids for obvious reasons, and may consist of milk, beef extracts, white of eggs, etc. Small quantities should be given at short intervals, as it must be remembered that the digestive function is always more or less depressed and can only do a portion of its usual work. A good reliable hematic is early necessary, one that can materially hasten hematosis without endangering the digestive and assimilative functions in any way, shape, or fashion. Pepto-Mangan (Gude) is one of the most dependable remedies of this class and its hematopoietic properties are well-known. Under its use the cellular elements of the blood are rapidly increased, and the whole physical condition is greatly improved. The various organs resume their functions and the distressing and dangerous effects of hemorrhage are safely and properly overcome.

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#### THE DIAGNOSTIC IMPORTANCE OF THE INDICAN TEST.

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That the profession is, each day, becoming more fully awake to the diagnostic and etiologic importance of Indicanuria, is evidenced by the increasing frequency with which this subject is considered in society discussions and medical journal articles. It is now generally acknowledged by all competent authorities that the presence of any considerable proportion of Indican (indoxyl-potassium sulphate) in the urine is definitely indicative of the undue putrefaction of proteid material in the intestinal

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canal and the constitutional absorption of the toxic products of such putrefaction. The average physician, however, does not seem to realize that the test for indican is not necessarily a laboratory procedure, but that, with but little time and trouble, he can readily determine the presence or comparative absence of indican in the urine and thus often quickly demonstrate whether or not the patient is suffering from intestinal auto-intoxication of auto-toxemia. As a guide to the physician in the making of this simple but important test, there is nothing more helpful than the Indican Color Scale, issued by F. H. Strong Company, makers of Chologestin, which is accompanied with a full interpretation of the several color reactions and a description of what is considered, by many authorities, as the most approved test. A request to the above named firm, 58 Warren street, New York, referring to this Journal, will bring one of the Color Scales referred to, together with samples of Chologestin for trial in the treatment of patients requiring combined cholagogue, digestive and antiseptic medication.

## A SUCCEDANEUM FOR MORPHINA.

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We meet with many cases in practice suffering intensely from pain, where from an idiosyncrasy or some other reason it is not advisable to give morphine or opium by the mouth, or morphine hypodermically, but frequently these very cases take kindly to codeine, and when assisted by antikamnia, its action is all that

In the nocturnal pains of syphilis, in the grinding pains which precede labor, and the uterine contractions which often lead to abortion, in tic-douleurux, brachialgia, cardialgia, gastralgia, hepatalgia, nephralgia and dysmenorrhoea, immediate relief is afforded by the use of this combination, and the relief is not merely temporary and palliative, but in very many cases curative.

Muscular spasms is often controlled by antikamnia and codeine tablets. Their action is of essentially the same character as the morphine action; the same parts of the central nervous system are affected, and in the same way as morphine, but not in the same degree. Nor do they induce habit.

In pulmonary diseases this combination is worthy of trial. It is a sedative to the respiratory centers in both acute and chronic disorders of the lungs. Cough, in the vast majority of cases, is promptly and lastingly decreased, and often entirely suppressed. In diseases of the respiratory organs, pain and cough are the symptoms which especially call for something to relieve; these tablets do the work, and in addition control the violent movements accompanying the cough, and which are so distressing.

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## ANNUAL ADDRESS OF THE PRESIDENT OF FULTON COUNTY MEDICAL SOCIETY.

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BY A. W. STIRLING, M. D., C. M., EDIN; D. P. H., ENG; ATLANTA, GA.

Gentlemen: The president of our society is admonished in chapter IV, section 2, of the By-Laws in the following words: "He shall, at the close of his administration, at the regular meeting for the election of officers, submit to the society an annual message, devoted to an account of his stewardship, and to the discussion of the interests, objects, and business of the society."

Now, it is generally I fear a much pleasanter task to dilate upon what one is going to do than to hold up for discussion what has actually been done. Yet we can look back upon 1908 as a year which has at least been full of subject matter for consideration: We have not been idle; much has been given, and much

received. We have heard and have debated more or less fully some 60 papers, the majority of which have undoubtedly borne the impress of considerable thought and labor, and some of which deserve high commendation as original contributions to the progress of medicine. A pleasant and generous spirit appears to have pervaded the discussions, and I think they have been generally enjoyed.

Our present plan of making an annual programme appears to work well, and I cannot make any suggestions for its improvement. I know that there has been here and there a feeling that sometimes our evenings have been rather full. That may now and then have been the case, and perhaps the affairs of the various committees may for that reason have been thrown a little in the background. On the other hand, I believe that to have been an error in the right direction, because unfortunately we cannot rely upon every member who puts his name down for a paper, being present to read it, and once or twice we have been rather shabbily provided for. On the whole I am in favor of beginning our evenings early and having one table well supplied.

Besides the reading of papers, we have had as a prominent part of our programme the exhibition of cases, specimens, and apparatus, and our thanks are specially due to Dr. Armstrong, and yet more to the gentlemen whose patients have appeared before us, for the trouble they have taken to make this an interesting feature of our meetings. It has, however, in spite of all efforts, not yet attained to the place of importance which it ought to hold among us. It will lie with the new president and his associates to decide what is the best plan whereby they may more deeply interest members in bringing cases before us. This might be made, perhaps, the most valuable department of our meeting; but it needs the hearty and active co-operation of those who are seeing out-door patients at the various clinics of the city. Some of us also are handicapped in so far that in order to see the lesions with which we have to deal, special apparatus is required, and such apparatus the society does not possess. We need such a combination of darkness and light as is suitable to the deeds we do. These instruments we must of course have. They will cost only a few dollars, perhaps \$10, \$15 or \$20 and I now for my part offer to subscribe \$5.00 of that amount. I understand that the room in which we now are is about to be handed

over to the society for its individual use. There can, therefore, be no objection to our putting in what apparatus is required. As the idea develops possibly it may be deemed advisable to add an X-Ray, and other more expensive apparatus for purposes of demonstration.

I should like to enquire at this juncture what becomes of those portions of the human form divine, which are being daily plucked from our fellow citizens. Doubtless they are scattered far and wide throughout this part of the country. They belong to all sorts and conditions of men, from the appendix of the society belle down or up to the biceps of "the horny-handed sons of toil," and these specimens are dead. Death levels all men; why not bring them together in the flesh, as they are already in the spirit? The colleges do not want them all; many of our number have no access to either college; we might have a useful museum here through contributions from men throughout the state. Perhaps our next president may see fit to bring such an idea to fruition.

There is a matter which has long appeared to me to be of vital importance, on which I have laid stress here, on several occasions, and in connection with which two committees were appointed last January: I refer to the indifferent part which is played by the medical profession in the public life of the family, the city, the state, and the nation. With your approval, forcibly expressed in the case of certain of our members a committee was appointed to provide at intervals, suitable papers for the journals of the city, with the object of educating the public on subjects which it is necessary for the general welfare that they should understand. I saw personally two editors, and each undertook to publish such contributions, one of them being indeed almost enthusiastic on the subject, while the other dwelt upon the necessity of the paper being written in a short, crisp and attractive form. A number of contributions were sent to the former, but with the exception of one which was worked over and re-written, by one of our number, they were merely excerpts from medical journals, and not one of them has been published. This may appear to be failure; but the matter is far too important to be allowed to die down. Our methods must be altered. It is obvious that the editors want something very short, and specially written for the occasion, and perhaps it is too much to expect a society



of the size of ours to produce a constant relay, once a week, or even once a month, of papers which it will pay the daily journals to print. Our refuge, therefore, lies in co-operation. As a matter of fact the central authorities of the American Medical Association should undertake the work, and I should be glad if tonight this society would pass a resolution to that effect to be forwarded to these authorities. But as they may never act, would not it be well for us to get in touch with the societies of the larger cities of Georgia and have a programme written for the year of unsigned papers to be produced by able writers, each to be published in all the newspapers of Georgia which desire them? I look upon this as a matter of vital consequence, and shall be glad to hear it discussed. The other committee to which I have referred had a similar object. Unfortunately that member who kindly undertook to guide it, was so long prostrate with typhoid fever that nothing has been done towards initiating that series of public lectures which we hoped to see in full blast this winter. I notice that a lady has come forward, and has already started something of the kind in this building, though not on medical lines. Possibly her forces and ours might be united, and accomplish something.

It is high time that scientific men, rather than the charletans of the advertising columns of the public prints should guide medical opinion among the laity. We never have done, and we are not now doing a tithe of our sacred duty. Our talents are buried in a napkin; our light is hid under a bushel. Something, indeed, a great deal, is being done to kill out tuberculosis, and our society has helped a little this year; but venereal diseases, infectious fevers, and rabies also require our strenuous attention. Publicity is specially needed in the matter of venereal diseases in order that women may have fair play in the game of matrimony.

We have an excellent state board of preventive medicine, of whose secretary we have special reason to be proud, but would not their hands be greatly strengthened by our moral support? Why do we have hundreds of cases of rabies being treated each year in Atlanta? And more than 40 at the present moment? Is it simply because of a defective insight, and energy among the authorities at Washington? An element of weakness in the practice of state control of legislation is seen here. The whole country should muzzle its dogs for a year and quarantine any

which enter it from without. In Britain rabies has in this manner being stamped out. Germany, I believe has done as much for its dogs and its citizens, which proves that a long land frontier it not an insurmountable barrier to success. If the national authorities cannot, or will not act, why should not Georgia make the attempt? Such would be at least an object lesson to others, and would show evidence that this state is farseeing and progressive in its ideas as well as grand in its imperial title.

Another matter which we have attempted to improve, is that of the relationship of doctor and patient in regard to collections. It is a mere truism to say that a debt is never a bond of union, but always tends rather to separation, while it is only reasonable as well as a universal experience that "short debts make long friends." There can be no doubt that the medical profession on the whole, is shamefully abused in this respect, and that an improvement would be a benefit to the community at large. It is interesting to observe that our idea of a central collector has recently been urged by Dr. MacCormack, the well-known organizer of much that is good in the American Medical Association. He also is strongly advising a greater uniformity of fees, a question to consider which one of our committees was appointed.

But I have said enough; and it remains only to thank you for your past kindly oversight of my defects as your presiding officer, and more specially for having honored me so highly as to have elected me three times to that place of importance. I have enjoyed every meeting, and I have learned a great deal from your transactions.

I had hoped to have here tonight a new gavel, which I was going to ask the society to accept as a small remembrance, but Atlanta is not yet big enough to keep many of these in stock, and if you will allow me, I shall hand it over to the new president at his inauguration in January. I again thank you, and wish you the old wish—A merry Christmas and happy New Year.

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The fifth semi-annual meeting of the Chattahoochee Valley Medical and Surgical Association will be held at Opelika, Ala., January 12th and 13th. Quite an interesting program has been arranged.

## THE RESULTS OF VACCINE THERAPY. IN ACUTE AND CHRONIC INFECTIONS.\*

BY J. EDGAR PAULLIN, B. A., M. D., ATLANTA, GA.

Of the many infections to which the human body is ever exposed, the organisms most frequently concerned are the streptococcus, staphylococcus, gonococcus, pneumococcus, meningococcus, bacillus diphtheriae, bacillus typhosus, bacillus tuberculosis etc. As a result of the invasion by these organisms we have established in the body a process which may be either acute, chronic, localized or general. In the acute infections the clinical picture varies accordingly as the number and virulence of the infecting organism, being in many cases mild and without systematic disturbances, while in other cases there are the usual symptoms observed in a severe toxæmia. Acute infections run a rapid course and end in either recovery or death. Chronic infections, on the other hand, are marked by an insidious onset without, as a rule, violent symptoms, and with a tendency toward very slow or practically no improvement.

Most infections are, however, localized, meaning by this that the invading organism is confined to some one particular area; in fact, it might be said that almost all infections are, in the beginning, localized and only become general on account of an inability of the body to successfully withstand the invasion of the bacteria so that they enter the blood stream, there multiply and are everywhere distributed throughout the body; producing the conditions commonly called septicaemia.

The portal of entry of these organisms is at a place far removed from the action of the blood fluids, or in that portion of the body which requires for its maintenance a comparatively small amount of blood or lymph. In other words, the organisms enter and multiply in an area of lowered bacteriotropic pressure.

In combatting the invading organisms, the body makes use of the protective substances normally present in the blood fluids—agglutinins, precipitins, lysins, opsonins, etc. Time does not permit a detailed statement concerning the action of each of these substances in protecting the body, yet it is generally believed that

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\*Read before Southern Medical Association, Atlanta, Ga.

a most important role is played in the protection of the body by the opsonin, and the amount of resistance offered to the invading organisms is proportional to the amount of opsonin present in the blood.

The work of Denys, Leclef and Mennes demonstrated that there is a substance in the blood which influences phagocytosis. Leishmann in 1902 published a simple method of estimating the amount of phagocytosis against the staphylococcus aureus in a patient the subject of this infection. It remained, however, for Wright to give experimental proof of the existence of a substance in the blood fluids which so act on bacteria as to cause them to be ingested by the phagocytes, and to show that the leukocytes when freed from blood serum possessed little or no phagocytic power. He showed that this substance, which so acts on bacteria as to render them capable of being ingested by the leukocytes, is present in the blood of normal individuals, and to it he gave the name of opsonin. About this time Neufeld and Rimpau made, independently, similar observations in working with anti-streptococcus serum. Later Opie and Barker have brought forward the fact that the leukocytes possess certain digestive ferments, leucoprotease, and it is by means of this that after the ingestion of these bacteria the enzyme so acts on them as to render the organisms harmless.

Wright has also called attention to the fact that in patients the subjects of chronic infections that the opsonic content of their blood is lower than that of an individual who is normal. For instance, he has shown that in a patient the subject of a chronic infection that the phagocytes of this patient when mixed with the patient's serum are not able to ingest as many bacteria as when the phagocytes are mixed with the serum of a normal individual. The question arises naturally then as to whether it is possible to raise the opsonic content of the blood so as to increase the power of the leukocytes to ingest bacteria; and it has been experimentally shown that this is quite possible and takes place when an appropriate vaccine is injected; much after the same manner as it is possible to increase the agglutins. It is entirely possible to increase the opsonic power of the blood so that it will influence many times more bacteria than the blood of a normal individual.

A word might be said concerning vaccines; a vaccine is a sterilized and standardized culture of an organism. The method

generally employed in making a vaccine is as follows: cultures are taken from the infected area and the nature of the infecting organism determined. Sub-cultures are then made and a twenty-four hour growth on agar is suspended in an 0.85 per cent. salt solution. The number of organisms in this solution are next counted by employing the procedure devised by Wright in which the suspension is compared to the blood of an individual containing a known number of red blood cells; equal parts of the suspension and blood are mixed, smears are made and the number of bacteria and red blood cells in several fields are counted. Knowing the number of red cells to the cm., it is easy to calculate the number of bacteria appearing in an equal amount of the bacterial suspension. Having determined the number of bacteria in the suspension, the vaccine is next sterilized by heating to 60 degrees Centigrade for one hour. Sufficient carbolic acid is added to make it up to 0.1 per cent. Cultures are then made from this vaccine to be sure that it is sterile. In case it remains sterile, the vaccine is ready for use.

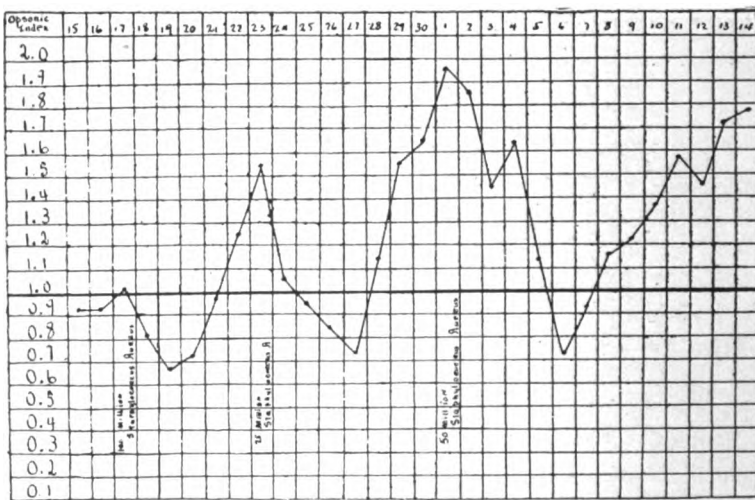


CHART I.

Following upon the injection of a vaccine, the condition of the blood is very instructive; shortly after the injection of the vaccine there is an appreciable decrease in the opsonins as evidenced by the fall in the curve—this is termed by Wright the “negative phase,” and there is with this a decrease in the antibac-

tericidal power of blood. In this chart the negative phase is quite marked on account of the fact that the initial dose of vaccine was large. Following upon the negative phase there is an increase in the antibactericidal substances of the blood as evidenced by an increase in the opsonic index; this has likewise been called by Wright the "positive phase." This positive phase may be maintained indefinitely by the regular administration of a vaccine. After the subsequent injections one observes that there is a drop in the measured opsonic blood content, but since the dose was reduced this negative phase was not so marked, neither did it last so long, and it rose higher after the previous injection. It is very easy to produce a series of negative phases on negative phases and by this means markedly decrease the patient's resistance to the invading organism by lowering the content of opsonin rendering the patient more susceptible to the action of the organism as is evidenced clinically by an aggravation of the condition about the infected area and an increase in its extent. On the other hand, it is just as easy to keep the index above normal provided one is familiar with the first signs of the negative phase as manifested by the clinical condition. The better way to be sure about this, to one who is not familiar with the negative phase clinically, is to determine the opsonic index, yet, as I have shown in a previous communication (*Journal-Record of Medicine*, April, 1908), there are many objections to this procedure.

A word might here be said concerning the site of injection of the vaccine. It has appeared to me that the best results are obtained when the vaccine is administered at a point near the area of infection and at a point in the path of blood and lymph passing to the infected area. As to whether this matters at all or not, I am not as yet prepared to definitely state, but it seems as though some of my recent cases have demonstrated this to be true. The vaccine should in all cases be administered subcutaneously.

In the following cases I have used altogether for purposes of vaccination personal vaccines—meaning by this vaccines made from the particular organisms which were the cause of the infection in each particular case with the exception of the cases of tuberculosis. With these I have used three different vaccines: (1) Koch's old tuberculin, made from the human bacillus. (2) Koch's old tuberculin, made from the bovine bacillus. (3) Koch's bacillen emulsion. The doses of the various vaccines from the

staphylococci have averaged from 10 to 100 million, depending upon the amount of resistance offered by the patient to each dose. The first dose has always been a small one, and has never been over 10 million organisms. In the use of tuberculin I generally give 1-100 of a milligram of Koch's old tuberculin as the starting dose, and occasionally give as high as 1-10 of a milligram over a space of time not exceeding three months. Of the bacillen emulsion the initial dose is 1-4,000 of a milligram of the dried tubercle bacilli, subsequently increasing the dose to as much as 1-500 of a milligram if necessary. I might state that the bacillen emulsion is composed of live tubercle bacilli which have been ground up, and, in order to be sure that no living organisms are present in this suspension, I heat this to 60 degrees Centigrade for one hour to be sure that the emulsion is sterile. I am convinced that the use of the bacillen emulsion gives better results than the other tuberculins mentioned. So in my cases now I am using only this.

CHART, NO. II.

| DISEASE.                          | Number of<br>Cases | Well | Im-<br>proved | Unim-<br>proved |
|-----------------------------------|--------------------|------|---------------|-----------------|
| Tuberculosis of skin -- -- -- 2   | 2                  | 1    | 1             | 0               |
| Tuberculosis of lung -- -- -- 3   | 3                  | 1    | 2             | 9               |
| Tuberculosis of bone -- -- -- 3   | 3                  | 0    | 2             | 1               |
| Tuberculosis of peritoneum -- 3   | 3                  | 2    | 1             | 0               |
| Tuberculosis of lymph glands--24  | 24                 | 8    | 10            | 6               |
| Gonorrhoeal arthritis -- -- -- 3  | 3                  | 2    | 1             | 0               |
| Gonorrhoeal prostatic -- -- -- 2  | 2                  | 1    | 1             | 0               |
| Chronic furunculosis -- -- -- 6   | 6                  | 6    | 0             | 0               |
| Carbuncle -- -- -- -- -- 2        | 2                  | 2    | 0             | 0               |
| Chronic pustular acne-- -- --10   | 10                 | 6    | 3             | 1               |
| Chronic infection of knee joint 1 | 1                  | 0    | 1             | 0               |
| Sinus following empyema -- -- 1   | 1                  | 1    | 0             | 0               |
| Sycosis-- -- -- -- -- 2           | 2                  | 2    | 0             | 0               |
| Sinus following drainage of ab-   |                    |      |               |                 |
| Streptococcus septicaemia -- -- 1 | 1                  | 1    | 0             | 0               |

Chart No. 2 shows the character of the cases which have been vaccinated. Of course, this has not been the only method used in the handling of these cases. Fresh air; sunshine; exercise; diet, together with local applications in some cases, have all been used. It is true that the number of cases is rather small, and no very definite conclusions can be drawn from them, but

the hope is that enough interest will be aroused in this subject to give the work of Wright a more thorough trial.

In this chart all of my cases, including those now under treatment, are figured. The first of the cases is one of tuberculosis of the skin which had been treated by various local and general measures for a period of three years. In order to be sure of the diagnosis in this case a small piece of the skin was excised and examined microscopically, with the result that numbers of tubercles were found in the tissue, as well as tubercle bacilli. I immediately began injections of the bacillen emulsion, commencing with 1-2,000 of a milligram and going as high as 1-500 of a milligram. Those injections extended over a period of four months, at the end of which time the patient was practically well of the disease. In the beginning of this treatment several pockets which had burrowed beneath the skin were opened up and curetted by Dr. McRae. Ten months since patient received last injection, result perfect.

Three cases of tuberculosis of the peritoneum have come under my observation, a girl of 18 years, a man of 20, and a woman of 34. In these cases there was a moderate amount of fluid in the abdomen. They were given tuberculin with the result that they are, to all intents and purposes, practically well.

There are 24 cases of lymph gland tuberculosis. Of these cases, 8 are well and 10 are improved. Included in the 10, there are 7 cases which have been under observation less than two months, and one case under observation ten months. Of the 8 cases well, these were under treatment from 4 to 8 months. One of these cases was discharged over a year ago and has remained perfectly well since. Of the 6 cases charted as unimproved, one has been under observation three months; one, a negro girl, who depended absolutely upon weekly injections of tuberculin to cure her—utterly disregarding the other measures advised; four cases have received only three doses of tuberculin, consequently little improvement is to be expected in their condition. I would call particular attention to the fact that the improvement in some of the cases of tuberculosis of the lymph glands after two or three injections of vaccine is quite marked. In one case the patient complained of considerable pain in the neck, which disappeared almost completely after two injections of vaccine. It has been my observation that, particularly in cases of bone tuberculosis,



there is almost always a cessation of the marked pain observed in these cases so soon as the vaccines are administered. As yet I have not had a sufficient number of patients with this particular disease to make a definite statement regarding this observation, but it has been a noticeable feature in those cases treated.

Of the three cases of gonorrheal arthritis, marked improvement was observed in two of the cases following the injection of the gonococcic vaccine., and in one case after the injection of 6 doses the patient refused to return for further treatment, giving as his reason that he was "perfectly well."

Another of these cases had a gonorrheal arthritis affecting the right knee. When seen, the condition had been present two months, in the meantime having been treated by various surgical procedures. When seen, he complained of great pain in the joint and there was a possible flexion of about 35 degrees. The tissue surrounding the joint was markedly infiltrated; quite hard and brawny to the touch. He was given 15 doses of the gonococcic vaccine. At the time when he passed from under observation he had a possible flexion of approximately 100 degrees and a complete cessation of pain. In this case, in conjunction with the vaccine, super-heated air and massage were employed.

There are six cases of furunculosis; two of these are physicians. In one there were 6 furuncles on the hand and 4 or 5 on the neck. This patient tells me that he observed marked improvement in his condition after the first injection of vaccine, in that the pain had diminished and within one week the boils had disappeared. This patient should have had another dose of vaccine, but he unfortunately had to return to his practice and could not wait the required time. As a result of this, one other furuncle returned after he reached home. The other cases recovered in three, four, five, ten and twelve weeks, respectively.

Ten cases of chronic pustular acne, of which 6 are perfectly well, 3 improved and 1 unimproved. Of the 2 improved, one of these cases has been under observation 4 months, the other 4 weeks. The unimproved case I am not able to satisfactorily explain, except for the fact that the young lady only had three small doses of vaccine. She decided that this aggravated the condition and refused to be further treated. Whether further injections would have benefitted her, I am unable to say. Of the ten cases, the staphylococcus aureus was isolated from 7; the

staphylococcus citreus from 1, and the staphylococcus albus from 2. Those cases which are perfectly well were infected with the staphylococcus aureus in 5; staphylococcus citreus in 1, and staphylococcus albus in 1. These cases were under observation from three weeks to five months. Occasionally there is a slight return of the former condition in one of these patients, but this is immediately remedied by a small dose of the vaccine.

Of the two cases of sycosis here figured, one of them was of a duration of two years, the other seventeen months. In both cases the infecting organisms were the staphylococcus citreus. Vaccines were prepared, and within three months from the beginning of the treatment the patients were perfectly well. In one, there was a slight return of the condition two months after being discharged, but a subsequent dose of the same vaccine immediately corrected this. These patients had been treated by local applications since the beginning of the disease.

An exceedingly interesting case was that of a sinus persisting from an old abscess in Pott's disease. In the same patient there was a sinus leading to the right ankle joint, the result of a tubercular infection. In this case cultures from these sinuses revealed the presence of the staphylococcus aureus, albus, and the colon bacillus. Vaccines were made from each of these organisms and injected into the patient. The sinus in the right ankle practically healed, but there was little improvement in the condition of the back further than the fact that the patient seemed to have less pain after the injections than previously, and there was a diminution in the amount of the discharge.

One very interesting case of streptococcus septicaemia was observed in which the above organism was grown from the blood. The infection evidently occurred following an abortion. Within 48 hours after the injection of the first dose of vaccine, which was 5 million streptococci, the temperature began to fall and there was a general improvement in the patient's condition. In all, five doses of vaccine were administered, and the patient recovered satisfactorily. Whether this was one of those curious cases that would have shown the same condition had the vaccine not been administered, I am not able to say, but I am inclined to believe that benefit was derived from this treatment.

#### CONCLUSION.

The conclusions that seem warranted from the above related facts and the report of cases are:

(1) That by the injection of a vaccine it is possible to increase the opsonic content of the blood fluids, and by increasing the index increase the resistance of the patient to invading organisms.

(2) That a vaccine to have the most beneficial effect should be prepared from the organism causing the lesion.

(3) Care should be exercised in the injection of a vaccine in order to avoid the production of marked negative phases.

(4) That the site of injection should be in the path of the blood stream to the part affected.

(5) That the most marked benefit from the injection of vaccines seems to be in those cases suffering from chronic infections, and in those particular regions of the body where the lymph flow is diminished.

Before closing I wish to express my most hearty thanks to Drs. Floyd W. McRae, W. B. Armstrong, C. W. Strickler, Michael Hoke, C. R. Andrews, L. S. Hardin, W. A. Crowe, W. P. Nicholson, L. T. Pattillo, and J. H. Johns, for referring cases to me, and without whose help it would have been impossible for me to have reported the above series of cases.

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## COMPLICATIONS OF GONORRHOEA IN WOMEN.

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BY F. G. HODGSON, M. D., ATLANTA, GA.

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Attention was first called to the importance of this disease by Bernutz and Goupil, as early as 1857, but the real gravity of the affection was not appreciated until after the appearance of Noeggerath's monograph in 1872. The gonococcus was first described by Neisser in 1879.

Gonorrhoea is usually contracted by sexual intercourse, but it undoubtedly may occur, especially in young girls by indirect infection from soiled clothes, water closets, etc. The gonococci once established in human body, may remain alive for ten to fifteen years or more.

In women the primary infection is usually in the urethra. The squamous epithelium of the vulva and vagina in adults is more resistant than the urethral or cervical epithelium. Children, however, readily develop a vulvo-vaginitis on account of the more delicate epithelium. Next to the urethra the cervical mucosa is most frequently attacked and this is followed by an endometritis.

Bartholins glands are not attacked until later, and this may be followed by inguinal adenitis or "bubo."

The symptoms of this disease usually begin with frequent and painful micturition due to the urethritis and often a cystitis. These symptoms may be very mild and not sufficiently troublesome to cause the woman to consult a physician. The next thing noticed is a purulent discharge which comes from the cervix and later the body of the uterus. This also may be overlooked or mistaken for a simple leucorrhoea. So it is possible for a woman to have gonorrhoea and to be ignorant of the fact. It does not, however, often continue this mild course. After unusual exertion, or excess, or after abortion or pregnancy the gonococci begin to grow very rapidly and finding the parts in a suitable condition they set up serious symptoms.

The germs invade the body of the uterus and produce purulent endometritis, they invade the walls and we have an enlarged and tender uterus. Menstruation becomes very painful, the flow prolonged and profuse. The infection then passes into the fallopian tubes and a salpingitis or phyo-salpinx results. An exudate of lymph occurs on the peritoneal surface of the tubes and adhesions form between them and the surrounding structures. The ovaries are next affected by continuity of or by an escape of the purulent discharge from the abdominal ostium of the tubes. Then we get more exudate and more adhesions until the tubes and ovaries become bound together and to the adjacent structures in one mass. By this time we have a well-marked pelvio-peritonitis. The structures are so bound together that they sometimes look as if cement had been poured into the pelvis and allowed to harden. In other cases a distinct abscess is formed in the cul de sac of Douglas and the adhesions are not so firm. When once infected these parts are subject to recurring attacks of pelvic peritonitis.

In regard to conception, it is estimated that 70 to 90 per cent. of cases of sterility are due to gonorrhoea. Many women once infected are never able to conceive—this is an important factor in the so-called "race suicide." In France where gonorrhoea is so prevalent, the birth rate is very low. If an infected woman does conceive she is more prone to abortion on account of the diseased condition of the endometrium.

Another complication which may arise as a result of the disease or strictured condition of the tubes is *ectopic gestation*, and this is as you know, a serious condition.

Another serious complication which may arise, especially in a pregnant woman is pyelitis. The inflammation extends from the urethra into the bladder and thence up the ureters. The ureters are pressed upon by the enlarged uterus and there is a partial retention of urine in the pelvis of the kidneys. This forms a suitable condition for the growth of the gonococci and the development of an inflammation. So we get a pyelitis. The next step in the progress of the disease is a pyelonephritis and then a pus kidney.

We have spoken of a pelvic peritonitis. In some cases this may extend and cause a general peritonitis. In other cases a general peritonitis may develop rapidly when the local pelvic symptoms are not marked and it may be mistaken for a peritonitis of appendical or other septic origin.

We have mentioned latent gonorrhoea with few or no local symptoms. These women may conceive and if none of the above complications arise they may bear fairly healthy children, but it has been shown by Lobenstine and Harrar that these children usually weigh less than children of healthy mothers. The initial loss of weight is greater and they regain their birth weight slower. They are more prone to have elevation of temperature and intestinal disturbances. But these are minor considerations when compared to that greatest of dangers, *ophthalmia neonatorum*. A committee has recently been appointed by the American Medical Association to investigate this disease and to try to adopt some method of controlling it. The writer represents the State of Georgia on that committee. You all know what a large percentage (about 60 to 70 per cent.), of the inmates of blind asylums owe their wretched condition to this disease, which is a preventable one, and it is a reflection upon society and especially upon the doctors that so many cases occur.

Now consider for a moment that the gonorrhoeal mother has escaped these numerous complications mentioned, and has born a fairly healthy child, and you have prevented ophthalmia by Crede's method she still is not safe. The gonococci may have remained latent so far but the uterus in the puerperal state forms a favorable medium for the growth and spreading of these germs. About the fifth day post partum or later we find a rise in temperature, pain and tenderness in the pelvis. The germs have ascended and attacked the tubes, and the chance for more children is gone. This has become so prevalent that we have the condition known as "one child sterility."

There is still another and more serious complication of gonorrhoea; besides the local manifestations of the disease the germs may enter the general circulation and produce a true bacteraemia. This may manifest itself as an inflammation in a joint and is known as gonorrhoeal rheumatism; or a true septicaemia may develop and the cocci attacking the heart valves produce a gonorrhoeal endocarditis which is usually fatal. A few cases of pyaemia with metastatic abscesses, phlebitis, pleurisy, and meningitis, all of gonorrhoeal origin, have been reported.

Dr. Alex Doctor says that venereal diseases are more serious than cancer or tuberculosis, for they produce more suffering and cause more deaths. Whether we accept this extreme view or not,

it indicates to what an enormous extent these diseases prevail. It has been said by Dr. Tabor Johnson that 70 to 95 per cent. of all abdominal operations are caused by gonorrhoea.

The worst features of the disease are: First, that so many women contract gonorrhoea in a perfectly innocent manner and may be wrecked for life, if not killed, in fulfilling the most sacred duty of life; and secondly that so many innocent babes have their sight destroyed and are doomed to a life of darkness and dependence, due to no fault of their own.

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#### TUBERCULOSIS.\*

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BY GEORGE BROWN, M. D., ATLANTA, GA.

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Tuberculosis. A name I never mention without a shudder, and think with Dr. Huber that: "It is with a real sense of melancholy that one contemplates the long death-roll of those of the world's great men and women who have succumbed untimely to the tubercle bacillus, which is and has been through countless generations by far the most potent of all death-dealing agencies. Had it not been for this detestable parasite Bastien Le Page might have given us another Joan-of-Arc to feast our eyes upon; Rachel might for many years have continued to permeate the spirits of her audiences with the divine fire that was in her. Our navy did well enough in the 1812 war, as all the world knows;

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\*Read before Southern Medical Association, Atlanta, Ga.

but what a rip-roaring time there would have been if John Jones had lived to take a hand in it. We might be reading some more of Robert Crane's splendid war stories; we might have had some of Robert Louis Stevenson's delicious lace-work; Schiller might have given us another Song of the Bells; we might have taken another "Sentimental Journal," with Laurence Sterne; Henry Cuyler Bunner might have continued to delight us, and to touch our hearts; John Keats might have given us another "Endymion." Had the tubercle bacillus permitted, Nevin might have vouchsafed us another "Rosary;" Von Weber another "Eury-anthe Overture;" Chopin might have dreamed another "First Polonaise;" and the tender flute notes of Sidney Lanier might even now be heard. Maria Constantinovna Bashirtseff, Lavier Bischat, John Godman, Rene Theophile Hyacinth Laennac, Henry Purcell, John Sterling, Henry Timrod, Artemus Ward, Henry Kirks White, Henry David Thoreau, Baruch Spinoza—such names as these are but a moiety among those of the world's nobility, whose precious lives were cut off in their prime by the "Great White Plague."

When a student looks back for the past nine years and reflects on what the world has done to alleviate the tubercular unfortunates, and realizes what the future has in store for them, we can but offer thanks for those devoted men and women who have been the pioneers in this fight, and can but pause a moment to give praise to those to whom praise is due.

I saw the birth of the first organized association in the United States to fire the opening guns of the campaign, which reverberated from Maine to Mexico. Since that time having put my hand to the plough I have never looked back.

Five years ago I started the agitation for a State Sanitarium for consumptives in this State, with little assistance from those who could give it and personal and general abuse from others. I have worked on until I can see an assurance that it will yet be built.

In submitting my name as a candidate for the House of Representative from Fulton County last June, I was overwhelmingly elected, heading the ticket with eleven opponents in the field by over 500 votes. This without any solicitation of votes on my part, only stating that I made the race *purely in the interest of the tubercular poor.*



The educational campaign can be said well established. There is no need, however, of any politician and "wise acre" jumping in and rushing into the front to educate the dear people.

What the dear people want is not education, but bread and meat and a place to sleep and medical attention for the tubercular poor. It is absolutely horrifying to read the Sunday papers and Magazines of today and see what harm they are doing. They are preaching to these poor unfortunates that fresh air and such rot is all any one needs to cure this disease.

In the name of God where are the people they have cured—listen to plain statistics. Averages cures incipient cases given proper Sanitarium treatment 60 to 74 per cent. Average cures home treatment, 1 per cent. Yet these miserable would be reformers are daily preaching to these people that there is nothing else that they need.

I beg to refer to the work of a plain elegant Atlanta gentleman and physician, Dr. Louis Rouglin, who helped to organize the first State Society here to fight this disease whose experience with this disease is not on paper, but who has turned out a large per cent. of cures.

He assisted in founding the first institution on modern lines in the South, The Pine Ridge Sanitarium, and it will stand near this city as a monument to his work and skill. These are the men who should have the proper credit for their work. Men who are curing patients and saving lives not writing newspaper stories.

I wish to cite your attention to the following cases, which I will be glad to show any one interested in this work.

Case 1. A. C. B., male, age 30, merchant, one brother died of tuberculosis in 1888, and in 1906, otherwise family history negative, past history negative.

Present History.—Contracted a cold latter part of March, 1908, coughed a good deal, took patent medicine for cough, but received no relief, began losing flesh rapidly and spit up blood on several occasions, had night sweats, and lost appetite, was growing weak, is troubled with shortness of breath, cough became worse and troublesome, patient lost 14 pounds, night sweats became exhausting and patient consulted a physician and he was told he had tuberculosis.

On Admission.—Patient looked emaciated, weak and short of breath, says he feels exhausted, cannot sleep on account of cough and night sweats, complains of pain in chest, and expectorates a

yellowish tenacious sputum of a foul odor, slightly blood tinged, tongue coated, weight of patient 121 pounds. Temperature at 4:30 P. M., 103 degrees, pulse 120, respiration 28.

Physical Examination.—Several signs of marked consolidation at upper right lobe, and evidence of cavity formation and evidence of involvement of lower right and upper left in a lesser degree; examination of sputum reveals numerous tubercle bacillis; opthamo-tuberculin test positive.

Subsequent History.—Patient was admitted July 10th, 1908 and continued to have marked evening elevation of temperature varying from 99.4 to 102.6 degrees F. until the 20th of July, when temperature became normal and continued so with the exception of a slight disturbance, this was soon corrected and temperature remained normal to date of patients discharge from the Sanitarium. Cough became less troublesome, on the 6th day after admission and finally ceased all together, night sweats stopped one week after admission, appetite improved and physical signs began to disappear, repeated examination of sputum since October 20th, failed to reveal any tubercle bacilli, and patient was dismissed November 8th, weighing 145 1-2 pounds, a gain in weight of over 24 pounds. Length of staying in Sanitarium, four months.

Case 4. T. H., female, age 14, school girl. Family and previous history negative. Present history began coughing and losing flesh a year ago, and troubled with night sweats, lost about 12 lbs. in the last ten months, had a hemorrhage and consulted a physician.

On admission to the Sanitarium, patient looked thin, markedly anaemic and nervous, complains of pain in chest and under shoulder blade and is troubled with shortness of breath, and hoarseness, physical examination reveals involvement of both upper and lower left lobe, examination of sputum revealed T. B., opthamo-tuberculin, test negative with 1-2 of 1 per cent. solution, positive later with 1 per cent. solution, evening temperature on July 19th, date of admission 100.20 F. Pulse 96 R. 24.

Subsequent History.—Patient continued to show evening elevation of temperature varying from 99 to 100.20 F. to August 22, when it became and continued normal to September 15th, when it again showed an evening rise to the 21st of September, since then patient's temperature was normal to date of discharge

from the Sanitarium, cough soon disappeared, and patient had no night sweat during stay at the Sanitarium, anaemia improved, and patient gained 30 lbs. in weight, hoarseness and physical signs disappeared and sputum is clear of T. B. Patient was dismissed November 8th. Length of stay, three months and 21 days.

Case 14. W. H. C., male, age 28, Banker. Father died from "Lung Fever" ten years ago, one brother died of tuberculosis two weeks prior to patient's entrance to the Sanitarium. Patient was constantly with his brother during the last three months of his brother's illness. Patient had catarrh and slight cough at last five years, cough has been growing worse, and is troubled with hoarseness, had no night sweats, expectorates in the morning and thick yellowish sputum, no blood, lost weight the last three months, and has an evening rise of temperature.

Physical Examination.—Shows involvement over entire left lung. Ophthmo-tuberculin reaction, and examination of sputum is positive. Patient was admitted on August 19th, ran a temperature varying from 99.8 in the morning to 101 and 104 degrees in evening, patient is very weak, eats and sleeps badly, this condition continued with but slight improvement to September 12th. when evening temperature fell to normal, and has remained so, appetite improved and patient rests comfortably, physical signs are rapidly disappearing and patient gained 35 pounds in weight since his admission to the Sanitarium, his last specimen of sputum still contained a small number T. B., patient was advised to remain in the Sanitarium for a short while longer.

In concluding this article, I can say that the facts brought out by the American Anti-Tuberculosis League three years before any other society was formed still stand as truths. That this disease is contagious and curable—that 80 per cent. can be cured if taken in time. That the greatest source of infection in the world is milk and inhaling germs, that climate never cured a living soul. That the Serum treatment offers in the hands of experienced and long trained men, the best results. That it can never be given with safety by a man who has not had a long and careful training in giving it. That the only hope for permanent cure is early diagnosis and sanitarium treatment, usually lasting less than six to twelve months.

That the doctor who does not give the patient a chance for his life by early diagnosis and proper care is a criminal.

## ADENOIDS.

DR. RIDLEY, M. D., ATLANTA, GA.

In selecting the subject of adenoids for this paper, I do so with the full realization that it is one which has been discussed in one form and another in a great many medical society meetings and by men of more ability and wider experience than I have or have had. In fact, there have been few important conventions at which the subject of Adenoids have not occupied a prominent position on the program.

Realizing all this it is not my intention to bring before this meeting that which is new, so much as it is to emphasize a few points which I consider to be important in the diagnosis, symptoms and relief of this pathological condition of the nasopharynx which has been found to be such a common affection and the relief of which has been attended with such brilliant results, in the health, growth, and development, both physical and mental of those who have had them.

It has not been so very long since it was determined that adenoids could produce such a chain of symptoms as we now know are the result of this condition in the nasopharynx, in fact, it is of comparative recent years that the symptoms that we now know are the result of Adenoids were not attributed to hypertrophied oral tonsils or to some stenosis of the interior nasal passage and when the tonsils were removed or the stenosis relieved the symptoms continued the Medical Profession at that time were baffled as to the cause. So here again is progress which we men of the medical profession may justly be proud.

Before entering into the real subject of the paper, I think it would be well to freshen our memories a little on the anatomy of the parts where this condition exists.

Situated back of the posterior nares, and at the junction of the pharynx is an arched cavity to which has been given the appropriate name of the nasopharynx. This cavity is limited above by the basilar process of the occipital bone, and posteriorly by the bodies of the cervical vertebrae. It is entered anteriorly by the openings of the posterior nares and on each side by the mouth of the eustachian tubes.

It is lined by mucous membrane which is continuous with that of the posterior nares. This membrane contains numerous mucous glands and is in folds and crypts whose walls are surrounded by lymphoid tissue similar in character to that of the oral tonsils.

Between the eustachian tubes and at the highest point of the nasopharynx, is quite a mass of the lymphoid tissue known as Luschka's or the Pharyngeal tissues and it is the hypertrophy of tissue that is known as adenoids.

Adenoids then is a hypertrophy of the tissue normally present and not a new growth as is frequently thought by the laity. Adenoids may appear as tough fibrous tumors or they may be of a soft, spongy character. When composed of this form they are generally pedunculated and may be likened unto a piece of cauliflower. When the brief description of the anatomy of the nasopharynx we can readily understand what a close relationship exists between Adenoids and several important structures. The symptoms and results of Adenoids are many and varied, though the most common symptom is that of mouth breathing. Situated immediately back of the posterior nares an enlargement here makes it difficult to breathe with comfort through the nose, the natural manner of breathing and as a result of the difficulty the patient breathed through the mouth. As a result of continued mouth breathing the patient is given an expression of idiocy and though he may be mentally bright he is not credited so from his looks and facial expression.

The natural lines of the face which give to it expression or lessen or destroy, and the eyes have a dull listless appearance, the bridge of the nose is broadened and the alae are pinched and thin. By continued mouth breathing the oral tonsils become hypertrophied, the crypts and lacunae deepened, which permit an admirable nest for the growth and increase of various bacilli whose toxins when taken up by the lymphoid circulation increase the liability of tuberculosis, rheumatism, diphtheria and other infectious diseases. The hard palate is often deformed and on account of the unnatural manner of breathing the lungs lack development and as a result of this the chest is badly shaped.

Again on account of the inability to breath through the nose the suckling babe is often taken from its mother's breast and placed on one or more of the many baby-foods which now flood

the market, when in fact, could the baby breathe properly while nursing the milk which the Lord intended for it would be nourishment sufficient.

There are other dangers which result from mouth breathing, but time will not permit an enumeration of them. Adenoids produce a catarrhal inflammation of the membrane of the nose which is most susceptible to sudden changes in the air, causing the throwing off of an enormous amount of mucous, giving the appearance of a "cold," and then the depressing action of some of the cold tars.

One of the most serious complications of adenoids is the acute and chronic suppurative inflammation of the middle ear closely related to the eustachian tubes. Adenoids throw off a discharge which is frequently loaded with infectious material and this is often forced into the mid ear through the tubes by a sudden cough, sneeze or blow of the nose and once the fire is lighted and cannot be checked until the cause is removed. Should this condition continue action there is always danger of mastoid involvement with its many dangers.

Reflex conditions which are often attributed to adenoids or malnutrition, absent-mindedness, bed-wetting, night terrors, general nervousness and many others. Chronic deafness and infection of the frontal sinus can often be attributed to this condition. The early recognition of adenoids is imperative for the future welfare of the patient, and for that reason it becomes the duty of the family doctor to be aware of the symptoms and dangers of adenoids and take the necessary steps to remove them before the complications have begun. I claim that the vast majority of the cases of adenoids develop in childhood and when found in adults they have existed since that time. In my opinion adenoids like all lymphoid tissue has a tendency and does atrophy in time, another reason why I advocate their early removal is on account of the permanent damage they may do before they atrophy.

The diagnosis of adenoids can frequently be made from a chain of these symptoms, when whoever this cannot be done, the nasal rhinoscope or the index finger introduced through the mouth into the nasopharynx readily reveals adenoids when they are present.

The latter method is the most reliable of all others for when once adenoids are felt it is rarely a mistake is made in the diag-

nosis. The condition most frequently mistaken for adenoids in this manner is a chronic catarrhal inflammation of the nasopharynx, when the mucous membrane is thickened and the crypts stand out more prominently than normal and when this condition is interfered with by surgical procedure more harm is done than adenoids would have done, had they been present, as it destroys the normal mucous glands and replaces it with a mass of acatrical tissue.

The treatment for the relief of adenoids can be described in a very few words. Operative procedure for their removal is the only treatment I consider.

For this operation as in all operations, the patient should be prepared by giving a laxative the night before, and nothing to eat within four hours of the operation. A general anaesthetic should by all means be used when not contra indicated and this pushed to completely narcosis where the pharyngeal muscles will be a state of relaxation. The choice of the anaesthetic is left to the experience and choice of the anaesthetist.

I know that in giving anaesthetic a great many operators differ with me, but I claim the operation cannot be done properly with a struggling patient. As soon as the instrument is introduced in a sensitive larynx the pharyngeal muscles close over it and limits its use to such an extent that if force be used the soft structures of the throat is often injured as is also the orifice to the eustachian tubes. The horror and pain of such an operation where the hemorrhage is as free as it is in this, often produces such a shock to the sensitive nervous system as to impair it permanently.

The result of such a procedure, I saw in one of our medical students, who was operated upon in this manner, who consulted me about a sensitive spot in his pharynx which gave him a great deal of pain in swallowing. Upon examination I found an area about 1-8 inch in diameter of denuded surface which exposed a part of one of the cervical vertebrae. This gentleman would not have had this to happen, had he been given an anaesthetic.

The ideal instrument to use for this operation is Gottstein Curette in some of its sizes and the finger nail of the index finger. I think with these instruments the operation can be performed thoroughly and satisfactorily.

I do not mean that you understand that I use the finger nail to remove the bulk of the hypertrophy, but it is simply used to clear out the fossae of Rosenmuller, a most important step in the operation. After the Curette has been thoroughly used first. I can not see how any one can claim to do this operation with their finger nail alone unless it is that the man who operates on the patient the second time does not inform him of the fact.

The position of the patient for operation should either be the Trendelenburg or recumbent positions, with the head over the end of the table or couch. As soon as the operation is completed the patient should be turned so as to permit the hemorrhage from being drawn into the larynx.

To keep the mouth open during the operation, the mouth gag is of course used.

The after treatment consists of a simple diet, for a few days, and an ordinary spray for cleanliness and lessen chances of infection and frequent blowing of the nostrils first one side and then the other.

And now, gentlemen, in conclusion, I wish to add that I have not presented this paper with any idea of having you believe that I am a literary genius, but merely to bring out a few points which I consider to be important in the diagnosis and treatment of a most common and frequent condition, adenoids.

The important points I wish to emphasize are:

1. The early diagnosis and treatment of adenoids.
2. The absolute necessity of using a general anaesthetic.
3. And thorough removal of all hypertrophied tissue by the use of the Curette and finger.
4. Care in not wounding the eustachian tubes and at the same time clearing the fossae of Rosenmuller from all the adenoid tissue.

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## HUNGER AND THIRST AND SOME MORE OF THAT SORT.

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BY DR. C. A. F. LINDMORME, ATLANTA, GA.

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I have said it at other places, and must insist upon it, that hunger and thirst, with some other notions, are not of a phy-



sical nature, but entirely psychological. In order to be corporeal they would have to be apt to show up in bodily specimens, which they do not; if they did, they would have to be presented by the investigator outwardly, and experimental proof which has never been afforded; while the proof that they are spiritual notions is being made every day, if only by the scholars the proper attention is paid to the matter; the difference is glaring enough. Hunger and thirst are an inwardness, never explored except as an inwardness. And so, gravitation, cohesion and adhesion, also pain, are spiritual notions. They have never been shown in fractions, or in portions, or regionally; gravitation, cohesion, adhesion, pain, enjoyment, are spiritual notions, a mentality; they are neither a compound nor an element; *they are ever a totality*. There is neither a greater gravitation, nor a greater appetite.

Hunger and thirst may show in extremes, but they show never by extremities, which they ought to do to, however, if they were bodily items. So it is with adhesion, cohesion, gravity, pain, ect. Sir Isaac Newton concluded gravitation from the bodily movements, but never gave out gravitation as a chemical substance; he did not tell us at all what he thought it was, but left it an uncertainty the supplementation of which we can rationally only find in mentality, the mentality of nature.

According to the ordinary conception gravity has its seat in the center of the earth. This is a very incoherent and lame reasoning. It is an impracticable theory. It is altogether one sided; there is no reason to attribute the force to one part only; to make it attraction only; but why should not the same force of nature live in the meteor? a meteor, in proportion to our planet is of too trifling a size to exhibit an indepenednt gyration, and is overwhelmed by the action of the earth, and consequently it is swallowed, absorbed by the enormous swing-force of the globe; but it is doubted by the same gravitation living in the increment from outside.

It is evident that hunger and thirst are no specific bodily objects; they never existed outwardly. They are an inwardness, totally, mind, or spirit or soul, a general feeling by which alone we can perceive the soul, or other mental object. It is only figuratively that we speak of a hunger like a wolf, because usually the wolf has to wait long for his meals. But it is withal, the same predicament; the simile is indistinct; just on acocunt of the men-

tal nature of all hunger. When a field of cauliflower has been without irrigation for a short while it exhibits in its impoverished ten times the length of endurance of droughth, we hardly notice looks the nature of its thirst. If a field of cotton is exposed to any deprivation at all, and so throughout nature the same variation; man, beast and plant. The stomach and ulterior alimentary canal of an inebriate is undergoing a desolate ruination extending even to liver and kidneys. I had a patient once, twenty years old, who drank cognac out of tumblers and by the bottle at a sitting. Should that not set the intestines on fire? Fire would have acted similarly. But yet the condition set up was not his thirst. His habit was. But then his habit was again spirituality, a compulsion which was neither cognac nor burnt up intestine, but just rack and ruin of his mind, or spirit, or soul, so that his cure was, first thing and foremost, the breaking in of abstinence. The patient I mentioned above I met once, shortly after an altercation, because his insensate drinking was threatening the house with a case of *delirium tremens*. He walked the streets solitarily, and I stepped up to him and invited him to take tea with be and and my wife. He accepted eagerly, and I got him to moderate himself during the rest of his term in the agricultural college which he attended.

It is the same with hunger. Leaving pronounced *boulaemia* out of consideration, because of its rarity, we may aver that over-eating is a very common occurence. The average man, especially the well-to-do one and mostly the rich, do not eat what they need, and would do them good, but as much as they think their stomach can bear, and moreover not what is good for them, but what they fancy and crave from habit of long standing. Virtue in our civilization is negative; the law-abiding man does not ask himself, what can I do to merit the record of a citizen, who, as much as he can, furthers the interest of the society I am living in, but shrewdly studies how must I act to evade the law, but yet pander to my greed and egoism, so the hygienic budget of the healthy man investigates how far he can go in his pleasant disdain of the rules of hygiene without incurring the risk of having to call in the M. D. Abernethy was right when he claimed, "the first disease by a debauch was made." Now, then, is the too much in the quantity only which was eaten. No, it is not; in right classification the things which tend to make up the bill of fare are bodies, sub-

ject to physical exploration, but the overeating in consequence of too much indulgence is a case of insanity, if you choose. It can not be designated differently. So is the setness of opinion that it is only meat which is a strengthening diet, and so is the uncouth obstinacy to keep at arm's length the argument that carnivorism is of closest kindred to cannibalism, a rudiment of evolution, indeed. The nitrogenous alimentation through bread out of whole wheat is fully adequate to that of the steaks and roasts, but does not pander to the long list of epidemic diseases of which the germ is harbored in the pork, beef and mutton-diet of the unphilosophical consumer.

The first rule of all hygiene is the limitation of the meals to only one course. Does it need more to condemn the banquets where there are seldom served less than half dozen? If a dish of porridge is not anything appetizing, then there is neither an occasion on hand to eat an hors d'oeuvre, and if a crust of graham bread is disdained, there is no need for a partridge either.

This seems to be all quite pedantry. It is not. I can array an experience of 75 years, and claim from the height of it, that vegetarianism exceeds carnivorism, taken all together, not only while being at table, but afterwards. With vegetarian habit there is no digestion-fever, nor is there mental irritation throughout life as in carnivorism, especially where indulgence in three times a day. There is a safe-guard in the observance of skipping meals. But if the meat-eaters think that the prescription of flesh-diet encroaches upon the enjoyment of the wonted repasts, they are very much mistaken; it is now already 28 years since I excluded meat from my diet, but I should lie if I were to admit that I do not enjoy my meals as I did formerly. If my dishes are more simple and plain, there is a compensation in the fineness of my taste. It took me half a year to establish the habit of vegetarianism, but am now so powerfully unused to it, that I should consider it as a sacrifice to have to give it up.

If my thesis that hunger and thirst are psychological items need yet an affirmation, it must be found certainly in the argument which the taste affords. Have we not pathological conditions, to excess, indeed, where depletion exists, and yet no hunger sets in? Moreover, what of the spirituality of love—hunger?

# EDITORIALS

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## HYSTERECTOMY FOR SPECIFIC INFECTION.

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The selection of the proper surgical procedure in the treatment of pelvic disease in the female is a matter of no small difficulty in many cases. Particularly is this true when the disease is of gonorrheal origin. Acute gonorrhea of the female pelvic viscera is not a surgical condition, but with the passing of acute symptoms, and after the most careful and prolonged application of local medication, we will have left a large per cent. of cases in which surgery is absolutely essential. In most of these cases the symptoms that are most urgent are usually attributed, and justly so, to the involvement of the fallopian tubes and of the ovaries, but we must bear in mind that once gonorrheal infection has spread beyond the internal os of the uterus, that organ suffers as much from its ravages as do the appendages, and is just as certain to be left crippled.

Without taking up the question of conservative work upon the appendages beyond noticing that in such work we take a grave risk of failure of symptomatic cure for a very slight chance of the occurrence of pregnancy, and a still slighter one of successful child-bearing, we will take up briefly the consideration of a condition in which the surgical indications are apparently clear enough, though they are persistently ignored. The performance of double salpingo-oophorectomy without removing the uterus might be justified when all ovarian tissue has been destroyed without disease or displacement of the uterus. However, when the tubes and ovaries have been so damaged by gonorrhea as to

necessitate their removal, nothing short of hysterectomy will meet all the surgical indications present.

The uterus is useless as a genital organ without the ovaries. Once the seat of a serious gonorrheal process it is ever afterwards practically useless under all circumstances, and with the ovaries out it is worse than useless, as it is a source of trouble and danger to the patient, and also to others through the infectious discharge coming from it more or less continuously. It is not only impossible to restore the uterus to anything like a normal condition after severe specific infection, but it is also practically impossible to destroy the infective process in the uterine cavity, and to render the uterine flow innocuous.

The necessity for removing this useless and dangerous organ along with the tubes and ovaries will appeal to us at once, unless its removal adds some considerable risk or the organ serves some purpose besides the genital function, which is lost after removal of the appendages, if not already destroyed by the disease. The danger of hysterectomy in practiced hands is very slightly, if at all, in excess of the risk of double salpingo-oophorectomy. Supra-vaginal amputation of the uterus requires little more time than is taken in doing thorough, neat work on the appendages; it leaves a much more satisfactory operative field, as is evidenced by the absence of raw surfaces. It is seldom after removal of the uterus that nearly, if not quite all denuded surfaces cannot be covered with sound peritoneum, and the operative field left in the best possible condition to prevent post-operative adhesions with attending discomfort and risk of intestinal obstruction.

Pan-hysterectomy offers advantages over supra-vaginal amputation in that the diseased cervix is gotten rid of. It is a more difficult and somewhat more dangerous operation, and should not be undertaken in this class of cases unless the patient's general condition is good, and the anatomy of the belly wall and of the pelvis lends itself to the procedure. In cases not suitable for pan-hysterectomy almost as good results can be gotten by coring out the cervix, removing the mucus membrane and possibly some of the cervical tissue. This gets rid of that portion of the cervix most apt to give rise to subsequent annoyance.

An objection at times raised to hysterectomy is that the uterus serves an important function as a support to the rectum and bladder, but this is hardly a valid objection, since the weight of

the uterus tends to favor its own displacement downward with consequent displacement of both these viscera. Any support it gives to the bladder from behind or the rectum from in front is readily substituted by proper technique in disposing of the remains of the broad ligaments. Without going into further details of this technique it may be explained that the stumps of the round ligaments and of the infundibulo-pelvic ligaments on either side should be drawn down and sutured to the stump of the cervix when it is left in, and to the vaginal wound when the cervix is removed. In this way the vagina is drawn up and supported in position while a diaphragm is constructed across the pelvic that gives as satisfactory support to the bladder and rectum as could be furnished by a normal uterus, much less by a diseased organ already displaced or with a tendency to become so.

This operation which removes only useless organs and which at the same time removes all tissue that is hopelessly diseased and incapable of restoration to anything like normal condition, which leaves a clean operative field without raw surfaces, and which leaves the supporting anatomy essentially intact, appears almost ideal for meeting the operative indications in these cases.. When we add to this the fact that it carries little more risk, if any, than does removal of the appendages alone, we are lead at once to the conclusion that it should be done in every instance in which both appendages need to be removed as the result of gonorrheal infection.

The operator without experience in doing hysterectomy may hesitate through awe for which he considers a much more formidable operative procedure, but practice rapidly produces confidence, and it is soon found that in hysterectomy for inflammatory disease the most difficult part of the work has been accomplished when the appendages have been freed from their pathological attachments. This of course must be thoroughly done in every case no matter which operation is to follow. Inexperience on the part of the operator might well be considered a valid objection to hysterectomy in these cases, but I know of no other and this is one that can be urged on the patient in exceptional instances only.

In specific infection of the uterus and its appendages surgical intervention is rarely indicated during the acute stage. After the subsidence of acute symptoms every effort should be made by prolonged local treatment and careful hygiene to restore the or-

gans as nearly as possible to their normal state, and so to avoid operative treatment. When operation proves inevitable the question of partial, so-called conservative, operation upon the appendages arises, a question of great importance which cannot be considered here. When judgment declares in favor of complete removal of both appendages then it is the part of wisdom to remove the uterus as well.

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### THE SURGICAL PROBLEM.

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It is no unusual thing to hear within our own fraternity statements concerning the numerous unnecessary operations which surgeons are said to be doing. "It is a sham" and "it is a crime" we hear it said that this or that was done in the surgical treatment of some case. Rather more charitable in any event where results were the reverse of expectations to have said "an example of error in judgment," "a mistaken diagnosis," rather than it was the result of "a mania for doing operations." or that "mercenary motives were dominant in the decision." While surgeons are human beings with characteristic frailties of their race, they are as a class humanitarians, full of charity and good works, sacrificing themselves for the general good. The same amount of sense, time, and money backed up by the untiring energy and zeal necessary for the development of a good surgeon or a good general practitioner would bring in far greater financial returns in any sphere of the business world, so that on the face of it is born testimony that the medical man is not a good business man, for if he were he would not be a doctor even though he had his license. Many men start out as physicians whose business acumen takes on early development and then they enter other avenues for the pursuit of wealth. A majority though small, follow the path of an honorable profession, preferring to do good in this special way, to serve the sick and weak, to live a shorter time, but crowding it with service and self sacrifice. That among the rank and file, there are sometimes found those mad for gain of gold as well as fame, that there are even department stores of surgery here and there, is not to be denied, for perfection has not yet become universal in the human race in general nor even among surgeons in particular.

In condemning surgery through the extravagances and extremes of some of the practitioners thereof, one should not be forgetful of the possible harm such a policy might inaugurate if persisted in as seems to be a tendency at present among surgeons themselves. No one individual should feel that he possesses the sum total of human discretion. It follows that repeated articles concerning "surgery gone mad" and the "furor operativus" if influencing surgeons alone might be productive of good, yet when added to a long and strong prejudice against surgery among general practitioners, many internists, and more electrotherapeutists and other utists, will be rather far reaching where the influence is finally spent, that is on the general public and their sick.

The surgical situation is really not the mad rush of ruthless removal of diseased organs, nor the ablation of those of doubtful pathology for be it said truthfully that in occasional instances when such is done it is rare that such lasting harm results as compared with the frequent loss of life which follows the refusal of operations from horror of surgery in both patient and general practitioner. Especially is this true of acute inflammatory conditions which often recover under medical treatment only to return in increased severity at some future time, when immediate surgical intervention as soon as the diagnosis is established means a certain cure with a minimum danger, a danger not to be compared with the risks of medical treatment. The real mortality of all acute surgical conditions such as appendicitis, gall bladder inflammations, perforations from ulcers, extra-uterine pregnancies, strangulated hernias, twisted tumor pedicles, intestinal obstructions, etc., arise from delay consequent to imperfect diagnosis, attempts at medicinal measures, and entertaining a hope that the case in hand is of a mild type and that it will be one of those to recover without an operation.

The question every doctor should put to himself is under what treatment do we obtain the higher per cent. of recoveries, in the case in hand, and then let the patient have the benefit of the most hopeful course. It is not a question of whether surgery has gone mad, it is not a question of whether it will benefit or do harm to the attending doctor's reputation, it is a question of human life and health to which no commercial argument should every apply in a decision as to treatment. How many countless



thousands have gone to their death because of delayed or no surgery in small tumors of the breast, in neglected lacerations of the cervix, because of medically treated appendicitis, or obstruction, or gall stones, no human statician will ever compute. When the cry is raised against the indiscriminate removal of healthy organs especially the procreative organs of the female and because of past error and present excessive zeal among a few, there is outspoken antagonism to the surgery today is as reasonable as an excuse for crying out against religion because of the error of a few preachers in keeping others from embracing a belief and living up to its helpful tenants, entirely overlooking the fact that it saves many souls, and affords a support at times when every other influence fails.

To the most of doctors who are in practice for the sake of the immeasurable good that lies within them to do for the sick of the human race, there is and can be no other duty but to the patient; fees, reputation, personal comfort and life itself is placed as a stake to overcome disease. Conservatism is a necessity for the continuance of medical and surgical progress, the stability of the profession as a scientific body is dependent thereon. Early diagnosis and immediate operation in those diseases where surgery offers a better statistical cure is conservatism of the best type and makes for progress and helps the education of the public in the knowledge of the usefulness of surgery and robs them of the fear of the knife. This fear is based on the results of surgery deferred till it becomes a last resort and where practiced as such is rarely satisfactory, for it leads to repeated operations and at best a partial cure in most instances. Take the same class of patients and allow them the privilege of early surgery and one operation of comparatively small danger cures permanently.

There is but one problem in the surgical situation, that being the early recognition of surgical diseases and immediate treatment by operation. All else as to extent of operation, removal of organs, of diseased tissues and whether this or that process will recover if left within the body is a matter of personal judgment, of the discriminative power of the individual surgeon based on past experience. The choice between drainage and ablation, between resection and removal, also comes under the surgeon's judgment as to whether this or that tissue has within it-

self sufficient vitality to further functionate, if not then its removal is conservative.

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#### THE FOURTH ANNUAL REPORT OF THE GEORGIA STATE BOARD OF HEALTH.

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The Fourth Annual Report of the Georgia State Board of Health has been issued and makes an excellent showing as regards the scientific work being accomplished in its laboratories, particularly the free examination of specimens for disease-producing germs. The report shows that this work is rapidly increasing, and undoubtedly the accuracy and additional interest thus produced will have a beneficial effect on the health of the state by fostering a scientific spirit among her physicians. The untiring efforts of the members of the State Board of Health and especially of Dr. Roy Harris, the secretary, have developed this body into one which wields a wide and wholesome influence throughout the state. They have continued the manufacture of tuberculin which has been extensively and satisfactorily used both in the diagnosis and treatment of tuberculosis. The various forms of tuberculin and their methods of preparation and use are described and physicians are urged to avail themselves of the advantages of this form of medication, in suitable cases.

The Board is now furnishing also free treatment for the prevention of hydrophobia by the method of Pasteur.

When an individual has been bitten by a dog thought to be rabid it is suggested that the wound be cauterized immediately and thoroughly, preferably with concentrated nitric acid.

Diphtheria autitoxin is now prepared in the laboratories of the State Board of Health according to the Gibson method and is ready for distribution to the citizens of the state.

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At the annual meeting of the Southern Surgical and Gynecological Association, held in St. Louis, December 15-17, the following officers were elected: Dr. Stuart McGuire, Richmond, Va., president; Drs. John Young Brown, St. Louis, and Robert S. Cathcart, Charleston, S. C., vice-presidents; and Dr. William S. Goldsmith, Atlanta, Ga., treasurer. Hot Springs, Va., was selected as the meeting place for 1909.



### OUR ROOF ~~AND~~ ~~THE~~ ~~REASON~~

#### JANUARY ISSUE DELAYED BY FIRE

The above picture shows more accurately than words can express the reason for the delay of the present issue of the Journal-Record of Medicine. We ask therefore the indulgence of our patrons for a few months until we are again in thorough working order.

## NEWS AND NOTES

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Dr. Chas. Boynton is in New York for several days.

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Dr. Amster, of Atlanta is still in New York City.

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Dr. and Mrs. James R. Garner announce the birth of a son.

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Dr. Eugene Murphy, of Augusta, attended the automobile races at Savannah.

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Dr. W. T. Bull still continues critically ill at his apartments, sixteenth floor of the Plaza Hotel, New York.

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Dr. and Mrs. Pattillo have returned from their bridal tour and are at home to their friends at Elizabeth street.

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The Tri State Medical Association convened at Memphis, Tenn., November 24th. Several very interesting papers were read.

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Dr. Wyman W. Pilcher, of Warrenton, Ga., was in Atlanta a few days since. Dr. Pilcher brought a case to the State Pasteur Institute for treatment.

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Dr. W. S. Goldsmith, of Atlanta was one of the speakers on the first day at the twenty-first annual meeting of the Southern Surgical Association, in St. Louis, December 16th.

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Dr. Smith Ely Jelliffe has retired from the co-editorship of the New York Medical Journal. Dr. Frank P. Foster remains, as heretofore, the editor-in-chief.

The International Typographical Union have appropriated \$10,000 to establish a tent sanatorium for the tuberculous in Arizona.

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Dr. Armstrong, Dr. Jas. H. Crawford, Dr. John S. Hurt and Dr. Willis Jones attended the automobile races at Savannah, November 25th to 26th. All report a delightful time and royal treatment by members of the profession in that hospitable city.

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At the regular meeting of the Fulton County Medical Society, December the 17th, the following officers were elected for the ensuing year: President, Dr. Cyrus W. Strickler; vice-president, Dr. J. Ross Simpson; treasurer, Dr. A. H. Lindorme; secretary, Dr. Edgar G. Ballenger; censor, Dr. Michael Hoke.

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It is with deep regret that we note the death of Dr. Andrew J. McCosh, of New York, Professor of Clinical Surgery in the medical department of Columbia University and visiting surgeon to the Presbyterian Hospital. The profession has suffered a distinct loss in the death of Dr. Cosh.

Dr. John P. Houston, one of the most prominent physicians of East Alabama, was struck by a train while driving. He received injuries from which he later died at his home in Arabecoochee.

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#### DEATH OF DR. C. C. STOCKARD.

It is with deep regret that we note the death of Dr. C. C. Stockard, a well known and highly esteemed physician of Atlanta.

Dr. Stockard died January 1, after a very sudden and severe illness, at the age of 55. He was a graduate of the University of Nashville and afterwards studied in Vienna. In 1892 he came to Atlanta, where he has been connected with several sanatoriums, making a special study of drug addictions. The remains were taken to his former home, Columbus, Miss.

## BOOK REVIEWS

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**GENERAL SURGERY.** A presentation of the scientific principles upon which the practice of modern surgery is based, by Ehrich Lexer, M. D., Professor of Surgery, University of Konegsberg. American edition edited by Arthur Dean Bevan, M. D., Professor and Head of the Department of Surgery, Rush Medical College in Affiliation with the University of Chicago. Authorized translation of the second German edition by Dean Lewis, M. D., Assistant Professor of Surgery, Rush Medical College, with 449 illustrations. D. Appleton & Co., New York.

This excellent volume on the principles seems to have lost none of its original value by its translation, but if anything has gained on account of the able editorship by Bevan and the careful translation by Lewis. All teachers we think admit that general or the science and art of surgery should be taken up before the student studies special or regional surgery. This book affords the student almost an ideal work from which to acquire such knowledge. If there is any criticism to make of the above book for such purposes it is that it is rather more comprehensive than the limited time of the student permits. Its greatest value will result to practitioners who are interested in surgery; they may read this book with great interest and profit. The busy surgeon will also find in its pages, clearly stated, all of the recent advances in the science of surgery, as for example the significance and importance of the modern conception of infection and immunity, and the application of this knowledge to surgery. Lexer has presented his views in a clear, concise and practical manner. Dr. Oliver Ormsby has written a comprehensive chapter on blastomycosis. We feel safe in recommending this work as the most valuable and comprehensive presentation of the scientific principles upon which surgery is based.

## PROGRESSIVE MEDICINE, VOL. IV, DECEMBER, 1908.

A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 333 pages, with 26 engravings and 2 colored plates. Per annum, in four paper-bound volumes, containing over 1,200 pages, \$6.00, net; in cloth, \$9.00, net. Lea & Febiger, Publishers, Philadelphia and New York.

The December issue of *Progressive Medicine* is fully abreast of the reputation of this quarterly for practical usefulness to every active medical man, whether physician, surgeon or specialist. In fact, its contents are purposely limited to the clinical as distinguished from the theoretical aspects of medicine. As brief examples of these characteristics, we may cite only a few of the multitude of topics treated by Dr. Edsall, of Philadelphia, in his 80 pages on Diseases of the Digestive System, if possible the most important in the entire range of human ailment. He points out the clinical bearings of recent physiological researches on the stomach and of psychic influences on digestion, deals with the results of recent x-ray advances in connection with that organ, devotes 10 pages to Gastric Ulcers, Stenosis and Carcinoma, revises to date the recently developed subject of intestinal diverticula, and illuminates the hitherto obscure field of diseases of the pancreas. In the same most cursory manner we may refer to the articles on Renal Tuberculosis and Syphilitic Nephritis in the secretion on the Kidneys, written by Dr. John Rose Bradford, of London. Bloodgood, of Baltimore, has covered in a hundred pages, the real additions to practical surgery during the year. His remarks on Surgical Shock deal instructively with a common and serious condition. He devotes twenty-five pages to advances in Surgery of the Blood-vessels, a subject of especial interest at the present time, and the same may be said of his articles on Surgery of the Joints. He closes with twenty pages on Tumors, thus completing in connection with his suc-

cessive sections on these morbid growths, the most important monograph on the subject in the language. Belfield, of Chicago, covers the latest advances in the Genito-Urinary field authoritatively in thirty pages. The Assistant Editor, Dr. Landis, closes the year with a Practical Therapeutic Referendum, reviewing the advances in both medical and non-medical treatment, and giving due prominence to untoward results following serum therapy.

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GONORRHOEA IN WOMEN. By Palmer Findley, M. D.,  
Prof. of Gynecology in the College of Medicine of the  
University of Nebraska, Omaha, etc. Published by C. V.  
Mosby Medical Book and Publishing Co., St. Louis, Mo.

In the above work Findley has collected much of value from the literature bearing upon gonorrhoea in women and especially as regards the sociologic consideration of this important subject. While the author does not deal with question as fully as one might expect in a monograph upon the subject, he has collected much of importance and such books, no doubt, will do much to open the eyes of the profession to a better understanding of the possible and likely sequels of uncured gonorrhoea in a careless husband, even though his disease is slight. While Findley has presented much of value, the matter cannot be said to be well digested; the style is careless and there is considerable repetition of matter in the quotations. The author speaks of the *inoculation* of gonorrhoea being the time elapsing between intercourse and the onset of the symptoms; we believe incubation should be used instead of inoculation.

Instead of digesting the matter to be presented and then giving it in his own language, he has quoted verbatim quite freely from numerous authors; the disconnection thus produced makes the work seem more like a series of valuable abstracts than a book.

In conclusion we would say that our criticism is rather of the method of presenting the matter than as to its truth or importance and we would consequently recommend that all who have vague ideas as to the frequency and danger of gonorrhoea and



as to its scientific management in women, obtain Findley's book and read it.

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GENITO-URINARY DISEASES AND SYPHILIS. By Edgar G. Ballenger, M. D., Lecturer on Genito-Urinary Diseases, Syphilis and Urinalysis Atlanta School of Medicine, etc. With 85 illustrations, 276 pages. Atlanta, Ga.; E. W. Allen & Co., Publishers. (Price, \$3.00.)

Wonder is frequently expressed that the medical profession of the South does not write more books. Southern doctors have the talent and the opportunity to produce as valuable a medical literature as those of any section of the country, and the indications are that the younger generation is awakening to this fact, and will give the world more abundantly in book form the results of its study and experience.

It is an event of unusual interest when a Southern physician does venture into such authorship. This is especially true when one succeeds as admirably as has Dr. E. G. Ballenger, of Atlanta, in his "Genito-Urinary Diseases and Syphilis," which has just come from the press.

For the place this book is intended to fill, it seems to be ideal. It is not put forth as an exhaustive treatise on the subject named, and yet it is far from being a compend. It includes all that is essential and up-to-date, and omits historical references and obsolete methods and illustrations.

The student and general practitioner will find in the book everything that they will ask to know in the management of ordinary cases of genito-urinary diseases and syphilis, and will be able to find it without having to digest unnecessary detail. The matter is well arranged, and handled clearly and accurately.

D. Ballenger is to be congratulated upon the pains he has taken with the volume, and upon the happy result he has achieved.

Frank K. Boland, A. B., M. D.

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## THE BORDERLAND OF DISEASE.

There is a growing tendency on the part of medical men to recognize the pathological importance of certain, at present, little understood conditions of the blood. Some of these indeterminate deviations from the normal present none of the aspects of the anemias, but nevertheless bear a direct relation to increased susceptibility to bacterial infection. The studies of Wright on the opsonins, so called, are of special interest in this direction, inasmuch as they have in a measure converted many of our abstract theories into concrete facts. That certain constituents of the blood may be diminished without apparent decrease of the corpuscular elements or of the hemoglobin, is at last fairly well established, and while the specific properties of these constituents are not as yet definitely known, there is abundant reason for attributing certain phases of malnutrition, as well as a general lowering of organic resistance to bacteria, to their absence or decrease. The

clinical expression of this blood weakness, or chemico-physiologic deficiency, is subject to great variation, but the symptom-complex usually consists of a general physical decline, loss of weight, increased tendency to fatigue, and a fickle or decreased appetite,—all of which go to make up a picture of what is usually loosely termed general debility. In addition, when the blood dyscrasia is marked, two objective symptoms are frequently noted. These are slight transitory enlargement of the cervical lymphatics, and a marked susceptibility of the skin to abrasions and infection. Imple injuries produce wounds that heal poorly and the processes of repair seem to be very feeble and inadequate.

This then in a general way constitutes what may be called the borderland of disease, a condition which even if it does not always precede tuberculosis, typhoid fever, pneumonia and many other diseases, certainly favors their development and tends to increase their severity.

The correction of this indefinite but none the less dangerous state of the blood is always urgent, particularly because of the favorable opportunities presented for increasing the resistance to those diseases to which it predisposes.

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## THE NEUTRALIZATION OF DYSCRASIA.

In a very excellent article on "Various Forms of Headache" which appeared in "*Medical Progress*" a short time ago, Dr. J. U. Ray, of Blockton, Ala., states that "we must not only be particular to give a remedy intended to counteract the cause which produces headache, but we must also give an anodyne which will relieve the pain until the constitutional dyscrasia to which this trouble is due, has been neutralized. To answer this purpose, two anti-kamnia tablets will be found a safe and convenient remedy. Usually they relieve the pain within twenty minutes. When we have a patient subject to sick headaches, we should caution him to keep his bowels regular, and when he feels the first premonition of an attack, he should take two antikamnia tablets. Most all patients tell us they know by certain symptoms when an attack is about to come. To these patients we can do nothing better than give them antikamnia tablets to be carried around with them always ready for use. They are prompt in action, and can be depended upon to produce the most soothing anodyne action. In this country and also in England these tablets are largely employed, with results that have caused them to be depended upon by the best observers in both countries. The remedy, having none of the drawbacks common to other agents of this class, it is eminently fitted to be applied in the treatment of the cases just described."

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## INAUGURAL ADDRESS BEFORE THE FULTON COUNTY MEDICAL SOCIETY.

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BY CYRUS W. STRICKER, M. D., ATLANTA, GA.

As a medical student I attended the meetings of this society. Since becoming a member I have attended with a fair degree of regularity. During these years I have spent many pleasant hours in your midst. I have learned much, not only from the dear departed, but from those present. I love this society and have a keen interest in the welfare. Therefore, knowing this, you may better appreciate my feelings, when I learned you had honored me by making me your president for the year 1909. Especially am I grateful to you for this distinction, when I look around me and see so many more worthy and who would have graced the chair with signal ability. I thank you for your kindness and

confidence, and assure you that with your generous and able assistance, I will lend my best efforts to make this the best year in our society's history, not for any praise that might come to me or any other individual member, but for the glory and common good of us all. I, therefore, ask each one of you to attend regularly and let us meet together with a unity of purpose, and in this way make each meeting profitable and pleasant to all.

This society under the leadership of our beloved and distinguished Scotchman, has made marked progress and I will endeavor to follow in his footsteps by advocating many of the measures noted by him in his annual address.

I wish to call your attention to the fact that the future success of this society depends upon its members. Unless you attend its meetings regularly, read papers, enter into the discussions and discharge faithfully all duties that may be imposed upon you, I see a failure in sight. I urge you to read papers, discuss papers and present cases, specimens and apparatus. I believe it would be a step in advance if this society would purchase suitable instruments and apparatus for the proper demonstration of cases.

I again call your attention to the great value of a library, and now that the opportunity for securing one is again offered, let each member contribute his share and help establish a library of which we can justly feel proud, and by using it, realize its value. It is needless for me to tell you that without it we will drift away and lose interest in scientific medicine and our ignorance shall become more appalling as the years go by. It is unnecessary and almost impossible for any one now to own all the literature necessary to keep him abreast of the times and stimulate in him the desire to make some advance in scientific medicine.

I suggest that the board of censors or a special committee be appointed and representing this society, call upon the editors of the various daily papers and insist that the names of its members be omitted when giving information regarding the illness of our various citizens. If our wish is not respected, certain demands might be made. It is high time that such a representative body of men take some steps to so unite in all their just desires, that their slightest wish would receive at least attention and all right and reasonable demands perfect respect. The high standard and

dignity of our forefathers is sadly lacking in most of us at the present day. May we make honest efforts to stop this decline and endeavor to emulate the physician of the old school, who was loved by many, possibly disliked by a few (?) but respected by all.

I have heard constant complaint of the miserable telephone service given members of this society. Considering the amount paid in yearly by us and caused by us to be paid in, I think we have a right to demand accurate and reasonably rapid service. If it is your wish, I will appoint a committee to look after our interest in this matter.

I have been requested to call especial attention to the importance of keeping vital statistics and of using proper prophylactic measures to prevent ophthalmia neonatorum. It is only right to say, that neglect, however slight, in the latter is unpardonable and we should use our most earnest efforts to prevent this calamity following in the wake of the social evil.

It should be a matter of great concern, not only to the physician, but to the laity, that articles necessary for public education should regularly appear in the daily papers. Our people will soon learn to appreciate our interest in their well being by heeding the advice given. I believe a special committee should be appointed to look after this matter.

The true physician never withholds aid from the needy sufferer, neither does he practice his profession for even dollars, not gloat over the gold that may fill his pockets. He has a higher purpose, nevertheless, we have to live and meet our obligations. We must do our duty to those dependent upon us. Therefore it is time for us to make proper efforts to control the highwaymen who hold us up and take what we alone can give. A central collector, I believe, is the cure for this practice, and the sooner we unite on this or some other plan, the better it will be, not only for our protection, but more so for him who is worthy, and in need. Your former president suggested and urged this.

The recent agitation in regard to the automobile ordinance gave promise of working many hardships upon our members who use machines, but our thanks are due Dr. L. C. Fisher for taking this matter up and securing for us the liberty of driving as the urgency of our work demands. Chief Jennings has instructed his men to show doctors this courtesy and to only take action in



cases of recklessness. Let us see to it that this privilege is not abused. In a short time some sign will be selected to designate our machines.

I have sent each member on our roll a communication requesting him to read one or more papers during the year. The program will be made out next week and it will be necessary for all titles to be in by that time. Kindly attend to this matter at your earliest opportunity.

The charlatan still resides and fattens in our midst. I urge that some effort be made to rid ourselves of, or curtail the operation of this blot on the page of medical history. This burglar for the unsuspecting and the innocent. If there is one really great service we could render the citizens of this city and state, it would be to forever banish this performer of miracles.

Many don't understand why this worker of wonders is not as honest and capable as he who guarantees nothing, promises little, but is ever honest and faithful in his efforts. I believe much can be done and I will urge the legislative committee to take this matter up and promise them my support.

I have thought it wise to utilize the time at our disposal in discussing plans for future welfare of our society. However, if any of the members desire the usual dinner speeches, their wish should be granted.

May we now bury all past grievances and have generated in our hearts a kindlier feeling and greater love each for the other, and put aside all that tends to disrupt or contaminate the whole. May there be no envy or strife in our midst, but an honest joy for him who succeeds. A helping hand and words of comfort and cheer for him who fails.

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#### REMARKS ON THE PRESIDENT'S ADDRESS.

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BY DR. JOHN C. OLMSTED, ATLANTA, GA.

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*Mr. President and Gentlemen:*

The admirable address which we have just heard, presents so many important subjects for our consideration, and contains such valuable suggestions, as to our future action, that I find myself embarrassed, in selecting an especial topic, with which

to open the discussion. I shall, however, begin with one, in which I have had some personal experience, as a member of the Board of Censors of this Society.

The President referred to the relations of the profession to the public press of this city; especially in the matter of newspaper notices, of members of our profession, in which the "operations" of certain physicians were exploited, and their connection with the cases of certain "prominent citizens" was heralded forth; I may say in gross violation of ethical propriety, and proper professional dignity—not seldom indeed, has the public been favored with the pictures of these distinguished gentlemen, in order, I suppose, that there might be no possible mistake as to their identity.

The President urged that we relax not our efforts to suppress this unprofessional "advertising," for it is nothing else, in the eyes of every right-minded, high-toned physician. Indeed, gentlemen, I believe that we are a scandal to the profession of the state, in this respect. Unless I am greatly mistaken, no such misconduct as this, exists, or would be tolerated, by the profession in Savannah, Augusta and Macon, which I mention, as being of Georgia's larger cities. Our President suggests that the influence of this society be brought to bear upon the editors of our daily papers, in explaining our position in this matter, and endeavoring to have them eliminate the names of physicians, in connection with "news items," of the character mentioned. I think this effort should be made, or rather continued; for it has already been made; and the President will readily recall his experience with Dr. E. C. Davis and myself, when as members of the Board of Censors, we called as a "Committee from the Fulton County Medical Society," several years ago, upon the editors of the three daily papers of this city. I may say that we were courteously received, and our statements listened to with patient attention; but I think we shall not soon forget, the amusing smile, that gradually suffused the faces of two of the more genial of them; a smile as of one pitying the ignorance of innocence! And then these gentlemen told us a few things. They mentioned how they were at times pressed by certain physicians, to put in these notices. "Why," said one of them, evidently putting himself under some restraint, "I reckon that you would be amazed to know the

names of some of these doctors; they are among the most prominent of the profession." Another editor informed us that their "medical items" were often furnished by one of their "news centres;" further explained that the chief "news centre" of his paper, were "the courts," "police department," "the jail" and "the hospitals," as regards local matters. In the case of one "hospital," its claims to recognition were so frequent and persistent, the editor said, that he had given orders that no notice be taken of its "news items," etc. We were enlightened in regard to some matters, which we had gravely surmised, but not positively known. Two of the editors expressed a willingness to carry out the wishes of this society, as far as possible, without conflicting with their function as purveyors of "news" to public. The third, was rather non-committal: viz: "If my paper doesn't publish such matters in which the public is interested, another will," etc. I believe, however, that good would come, if this society presses this matter further, by formal action, and transmitting its sentiments, in the form of a request, to the editors of these papers. It is indeed humiliating, that we have to invoke such aid, in protecting the ethics of the profession, from infraction by its own members; yet only those of us, perhaps, who have occupied the unhappy position of membership on the "Board of Censors," can appreciate the difficulties, and embarrassments encountered, when endeavoring to investigate, and exercise our duties, in such cases of infraction.

The ignorance claimed as to "how such a notice got into the paper" is truly pathetic; as is also the negation of all knowledge as to "how they got hold of my picture!"

There are, it would seem, among the insoluble mysteries of our present state of existence! All of this too, in the face of certain specific data, minutive of detail, sometimes even biographical of the doctor, which would plainly indicate the source as being the innocent victim himself. Of course, we are aware of cases, or rather instances, in which a physician has been made the victim of well-meaning, but mistaken friends, who only meant to do him a kindness, by giving him a "good send off" before the public; but this only shows the effect upon the public mind, of the demoralizing results of the advertising members of our profession, in degrading their noble calling, to a commercial level.

Let me devoutly express the hope, that as regards the Board of Censors, and this class of offenses, that this new year will be one of blessed calm and freedom!

A few words on another topic, and I will not further try your patience.

The President has rightly suggested our duty to the public, in regard to taking some measures to enlighten, and protect them, as concerns the abounding quackery in this city. Georgia has long been the "dumping ground" of unscrupulous medical quacks; and Atlanta, if she is not "the State of Georgia" (as is claimed by some) is certainly the centre of this industry.

We should not be discouraged by past failures in this direction. I recall some of these. It sometimes seems as if the public did not wish to be "protected" from these quacks, and that the saying of P. T. Barnum, "the American people love to be hum-bugged," is especially applicable in this instance.

The regular profession is presumed to be jealous of the "Indian remedy," the negro's recipe, and the wonderful concoction of "Old Dr. Gridly!" I recall the case of a notorious quack whom we prosecuted some years ago. We had the most conclusive evidence, complying with all the technical requirements of the law; the judge's charge pleased us, but so did not the jury's verdict, which acquitted the rascal, promptly. As I have quoted Barnum's classic remark, I will quote another classic one as expressive of my feelings on this occasion; it was that of the late Commodore Vanderbilt; "the people may be d—d!" However, this sort of philosophy won't do; we must be more patient, and philanthropic.

But sir, if we are to accomplish results in this matter, whether in municipal or state legislation, it must be by the co-operation of the three recognizedly legal medical systems of this state, Regular, Eclectic and Homeopathic. These three professions stand equal before the law, and their harmonious and combined action, in all medical legislation must be obtained, if effectual warfare on the common enemy of illegal practitioners is to be waged. They have co-operated with us in the past, they will do so, I am sure in the future, and are capable of wielding a powerful influence upon public opinion, for we must remember that with many of the public, their influence is greater than our own.

But, I have already occupied too much of your time, and will

only say in conclusion, that I trust all your efforts in the varied fields before us, will result in the upholding of the best traditions of a noble profession, in an age of commercialism, and recall to our benefit, as remarked by our President, those high ideals of an older day, which, whatever were its short-comings, caused the title of "Doctor" to be respected.

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### BLOOD IN THE URINE—SOME CASES.\*

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BY ALFRED L. FOWLER, M. D., ATLANTA, GA.

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PROFESSOR OF GENITO-URINARY SURGERY AND VENEREAL DISEASES  
IN THE ATLANTA COLLEGE OF PHYSICIANS AND SURGEONS;  
GENITO-URINARY SURGEON TO THE GRADY HOSPITAL;  
PHYSICIAN AND SURGEON TO THE UNITED  
STATES PENITENTIARY HOSPITAL; SUR-  
GEON TO ST. JOSEPH'S INFIRMARY,  
ETC.

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The physician who desires to gain a keener insight into the urinary hemorrhage can only acquire it by the careful thought and study necessary to comprehend its true meaning. The ability to manage it, together with the many perplexing conditions that frequently arise, becomes much easier when a thorough knowledge of all its causes and details are mastered; so that the labor required to control it is fully bestowed. Hematuria is the most important objective symptom of the genito-urinary tract and is common to many of the grave affections involving the genito-urinary organs.

Blood appears in the urine as the result of several distinct and separate affections of the uro-genital tract. As examples:

- 1.—External trauma (a blow from without) may so damage the kidney, the prostate, the testicles or the penis sufficiently to cause hemorrhage of these organs which subsequently finds its way into the urine. Internal trauma to the uro-genital membrane such as the passage of the renal calculus, the movements of a large vesical calculus, clumsy instrumentation in catheterization or cystoscopy on the part of a neophyte, may also give rise to it.

- 2.—Local diseases, such as acute Bright's, cancer, sarcoma,

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\*Read before the Fulton County Society of Medicine, January 7, 1909.

parasitic diseases, such as *Bilharzia haematobia* and particularly gonorrhoea and tuberculosis; drugs, benign villous tumors, hy-

3.—Constitutional or circulatory diseases dependent on depravity or disorganization of the blood, such as pernicious malaria, scorbutus, purpura hemorrhagica, typhus fever and syphilis.

4.—Vaso-motor disturbances to the sympathetic system—persistent active hyperaemia and, very rarely, passive congestion concomitant to obstructive cardiac lesion.

While the presence of blood in the urine is not, of itself, an essential disease, it being merely a symptom, we should remember that occasionally some of its causes are so thoroughly veiled in obscurity that we find ourselves unable to detect the precise pathologic condition upon which much depends. Particularly is this true if we are not thoroughly familiar with all its probable causes. It is only by careful thought and study of all the available data at our command that we can arrive at a correct diagnosis.

Besides the valuable data obtained by interrogating the patient, which will give us a presumptive diagnosis, it behoves us to verify our suppositions by resorting to the exact methods of examination.

The most orderly way of beginning an examination is to take an accurate anamnesis. We endeavor to learn just what diseases have occurred in the patient's family and of what particular maladies his near relatives died. This inquiry may disclose the fact that tuberculosis, rheumatic and gouty affections, or lithiasis occurred in the patient's family because these diseases play an important role in heredity.

From the patient himself we must endeavor to learn, besides his age, nativity and temperament, whether he has ever had gonorrhoea, syphilis, scarlet fever, hemorrhoids, traumatic injury or other significant diseases.

Having secured all the information obtainable concerning the patient's present illness, its mode of onset, its course and duration, the following detailed information should be sought with the object of at least arriving at a presumptive diagnosis, to be verified later:

When was blood first observed in the urine?

Was the blood clotted or in solution?

Has the blood in the urine ever completely disappeared at any time? If so, how many days at a time?

Does the hemorrhage always take place under the influence of motion? (Note 1).

Does bleeding occur suddenly? (Note 2).

Does it come on without apparent cause and last a long time? (Note 2).

Is the hemorrhage difficult to control by treatment? (Note 2).

Does the influence of rest have any apparent effect on the hemorrhage? (Note 3).

Does hemorrhage appear at the end of urination? (Note 4).

Is the urine smoky and is the blood uniformly diffused through it? (Note 5).

Are there any hemorrhoids present?

Does the first glass of urine expelled contain clots? (Note 6).

If so, is the blood coagulum dark and firm? (Note 6).

Is there little or no blood visible until urination is about completed? (Note 6).

Does bladder instrumentation increase the hemorrhage? (Note 7).

Do solutions of aluminum sulphate, silver nitrate, antipyrine or adrenalin check the hemorrhage? (Note 7).

Does the first glass of urine expelled contain blood? (Note 8).

What is the difference in the relative quantity and quality of blood contained in the first, second, or third glasses?

Is urination more frequent than formerly?

Is the urgency of urination present both day and night?

Is the desire to urinate more frequent in the day than at night?

(Note 9).

Does rest exert any influence upon frequency of urination? (Note 10).

Does activity during the day seem to increase the number of urinations? (Note 10).

Is the quantity of urine passed normal and urination frequent? (Note 11).

Is the quantity of urine passed larger than formerly? (Note 12).

Does the patient sleep all night without having to urinate? (Note 13).

Is the desire to urinate more frequent at night? (Note 14).

Is the urine expelled in an arched stream or does it fall perpendicularly? (Note 14).

Is the urination ever suddenly arrested?

Is there ever any pain over the bladder?\*

Is there ever any pain in the region of the kidneys? (Note 15).

Is there ever any pain in the urethra?

If in the urethra, is it near the end of the penis or in the deeper portions of the urethra? (Note 10).

Does the pain follow urination? (Note 10).

Does the pain last some time thereafter? (Note 16).

Does pain occur independently of urination? (Note 10).

Does exercise increase the pain?

Does rest lessen the pain?

Is there often felt a dull, aching pain in the perineum and rectum? (Note 14).

Is pain felt only upon urination? (Note 17).

Additional information, other than that gained by interrogating the patient, may be had by a thorough examination of the urine. This should be done macroscopically, microscopically and chemically. These means afford us valuable aids in diagnosing the disease.

By reason of the difference in the character of the blood present in the urine we make two divisions of hematuria, namely, *hematuria* pure and simple, and *hemaglobinuria*. In conditions of the first class the blood corpuscles exist intact in the urine; while in conditions of the second class the corpuscles have become disorganized and liberated their hemoglobin, hence the discoloration of the urine.

Occasionally the hemorrhage is so slight that we are unable to detect it macroscopically. In such instances the microscope will generally serve to detect the presence of blood cells; unless their hemoglobin has been liberated (hemoglobinuria), when the

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\*Pain in the region or high up in the perineum points to hemorrhage from bladder or prostatic urethra.



spectroscope may be necessary to determine their presence.

Apart from the spectroscope and microscope, there are several chemic tests that are both simple and practical. The most popular of these, perhaps, is the one known as Day's test. This test is made by adding a few drops of a fresh alcohol solution of guaiac (It is very well to bear in mind that in patients taking the iodides, the guaiacum test, even when blood is absent, gives a greenish blue reaction.—*The Hospital*, Oct. 24, 1908) to the suspected urine and then a small quantity of ethereal solution of peroxide of hydrogen. If blood be present a blue reaction results. The ordinary spirits of turpentine (old oxidized turpentine is more trustworthy) and tincture of guaiac when added to urine containing blood also give a decided blue tint.

The gross or microscopical appearance of the urine generally furnishes information. The simplest way of conducting this examination is with the three glass test.\* The difference in the color of the urine will be more striking if the patient only expels a drachm or so into the first glass, while into the second glass the bulk should be passed, and into the third the few remaining drops still contained in the bladder. If blood be present in the first glass (fluid blood appearing with the first portion of the stream comes from the deep urethra or prostate. If extensive it may discolor, by flowing backwards, the entire contents of the bladder. The urethroscope may be necessary to settle the question. Goldschmidt's urethroscope through which water, under pressure, is used to dilate the urethra, will in such instances serve our purpose best) and not in the second glass of urine the hemorrhage must be coming from some point anterior to the internal sphincter. If present in the second and not in the first glass, we must look to the kidney, the prostate or the bladder. If next we thoroughly irrigate the bladder and the flow returns clear and then after waiting awhile so as to examine the third glass and find hemorrhage, naturally we suspect either the ureter, kidney or its pelvis.

In a general way, it may be stated that if the blood is of a bright hue the condition giving rise to it is usually benign; also that the nearer the hemorrhage to the vesical neck the brighter the

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\*The seven glass test of H. H. Young, which even goes a step further than Kollman's five glass test, is a combination of the three glass test and the irrigation test. It requires a little more technique, but it is of undoubted value in obscure and selected cases.

color of the urine; while on the other hand, urine containing blood from morbid or malignant processes is generally of a darker color. When the hemorrhage is urethral it is always washed away with the first gush of urine, provided it does not escape independently of urination. If the urethral hemorrhage has coagulated it is generally discharged as a long, pencil-shaped coagulum and the second glass test will flow comparatively clear; while at the end of micturition the cut-off and accelerator urinae muscles will generally force out from the injured part a varying amount of almost pure blood into the third glass.

Hemorrhage from the prostate is apt to contain clots whose general contour and size are suggestive of the prostatic sinus. Such clots are dark and firm, and pure blood is not observed until urination is nearly completed.

If stone in the pelvis of the kidney is causing the hemorrhage, caudate cells may, in addition to red blood cells, be detected with the microscope. Caudate cells, however, lose their significance when the neck of the bladder is diseased, unless we have collected the urine from each kidney separately through *ureteral* catheters directly from the kidneys. In *acute nephritis* the microscope will show blood casts, epithelium from the renal tubules in the form of casts and, usually, caudate epithelium from the pelvis of the kidney.

Hemorrhage from the ureter is occasionally expelled in clots in the shape of angle worms. This is of importance when differentiation between a vesical and renal tumor is to be made.

In order to complete the examination and verify any presumptive diagnosis we have made, it is, of course, necessary to examine the patient himself, since the final examination may greatly change or modify our opinion as regards the true cause of the hemorrhage.

On the contrary, it not infrequently happens that the information brought forth by the foregoing investigation is so clear and to the point that we can diagnosticate, quite clearly, the underlying cause of the hemorrhage solely by exclusion.

1.—The physical examination should include a thorough examination of the patient's physique, his general make-up; an examination of the heart for lesions; the kidney for the presence of pain and tumors; the rectum for hemorrhoids; the prostate for enlargement; the seminal vesicles for inflammation; and also the

base of the bladder itself. In addition to the foregoing the pelvic organs, the bladder, the penis, the testicles and the scrotum should be carefully examined. All this had best be done *without* instruments.

After the examination has proceeded thus far, the best plan is to put the patient to bed for a few days in order that we may better study the case further before examining the urethra and bladder with instruments; for there is danger to these patients in acting *too quickly*. This not only gives us time to give careful thought and study to the case, but affords an opportunity to give him absolute rest; while at the same time we put him on what is practically an alkaline diet: bread and milk. Meanwhile his bowels should be thoroughly evacuated by a mercurial and his kidneys flushed with some good spring water, and an urinary antiseptic—oil of eucalyptus and salol, in 10 minim and 10 grain doses, respectively (capsules), or urotropin in 5 grain to 7 1-2 grain doses is given. Cystogen answers very well, but it is about the same thing as urotropin, only its price is higher. It is a rule to which I have seen no exceptions, that patients receiving this preliminary treatment invariably stand the stone searcher, cystoscopy, urethroscopy, and both ureter and bladder catheterism far better than those not receiving it. In conditions of emergency this preparatory treatment cannot be given and, moreover, in emergencies, cystoscopy and urethroscopy are of little or no value.

2.—The emunctories having responded and the patient having rested the patient is now in prime condition for an urethral examination, at least. If the meatus is small meatotomy should be done, so that the meatus will easily admit a 32 (F.) or 34 (F.) soft, flexible bougie à Boule. It will be necessary to use bougies, corresponding in size to the bougies à Boule, not less than every other day for a week or ten days to prevent the meatus from growing up and actually becoming smaller than it was originally; for at best even when the bougies are used regularly, the meatus will generally contract 2 to 4 millimeters. With the bulbous bougies we can detect any organic or spasmodic strictures that may be present.

By introducing the urethroscope the color, lustre, duplicature and striation of the mucous membrane are observed. Besides erosions and organic stricture, the urethroscope will disclose poly-

(TO BE CONTINUED).

## ACUTE TRAUMATIC TETANUS TREATED BY MAGNESIUM SULPHATE.

WITH REPORT OF A CASE IN THE TREATMENT OF WHICH INJECTION OF AN AQUEOUS 25 PER CENT. SOL. OF MAGNESIUM SULPHATE WERE MADE IN THE SPINAL SUBARACHNOID SPACE; WITH RECOVERY.

BY AIME PAUL HEINECK, CHICAGO, ILL.

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Our knowledge concerning this acute infectious disease is incomplete. Numerous are the features of this intoxication that call for elucidation. We know that the disease occurs sporadically, endemically (1), and epidemically; that there is no age, sex, or race that is immune. It has occurred in Iceland. It is very prevalent in the tropics. In reference to race incidence, it must be stated that it is considered by most observers to be more frequent in the dark-skinned races than in the white race, even in the same country. The disease has a variable period of incubation; on an average in the acute form, from five to ten days elapse between inoculation and the appearance of the symptom-complex of this condition. A short period of incubation implies intensity and virulency of infection, and is of bad prognostic omen. Though it is not believed that one attack confers immunity against other attacks, cases of second attacks are not known (7).

Though this disease is comparatively rare, it occurs in such unforeseen (8) conditions, and usually has such a dramatic outbreak and such a fatal termination, that it is of interest to all medical practitioners. It has complicated burns (2). It has complicated frost-bites. It has complicated horse-bites. It has followed such insignificant trauma as is associated with the hypodermic injections of quinine (3), with the subcutaneous administration of antiplague serum (4), with the application, for hemostatic purposes, of gelatine to bleeding surfaces, with the subcutaneous employment, for hemostatic or other purposes, of this same agent

(5) with the operation of vaccination (6), of circumcision of the removal of adenoids. It has followed the employment in operative procedures of contaminated catgut; it has followed contused wounds of the outer canthus of the eye (9), and other wounds so insignificant that at the time of infliction they passed unnoticed, or if noticed, they were completely forgotten at the time of the outbreak of the disease. The disease may occur after childbirth, and may occur after abortion, accidental or induced (10). As a result of Fourth of July injuries in 1903, there were 406 deaths from tetanus as compared with 60 from other sources (11).

Since the discovery by Nicolaier, in 1885, of the bacillus tetani, and its growth, in pure cultures, by Kitasato, in 1889, it has been amply demonstrated that all clinical forms of tetanus; cephalic tetanus (12), tetanus neonatorum (13), puerperal tetanus (14), post-operative tetanus (15), traumatic tetanus, are due to the bacillus tetani. The inoculation of the offending germ occurs through an abrasion or through a wound of a cutaneous, or a mucous surface. Tetanus is an implantation infection. In the lower animals, all experimental efforts to produce the disease, through either the respiratory or the alimentary tract, have proven unsuccessful. In man, as far as we know, the same condition obtains. No case is on record of the disease occurring in man as a result of infection taking place by inhalation or ingestion of the tetanus bacilli. The bacillus, though not a pyrogenetic germ, is not hindered in its development by the presence of the germs of supuration. The latter, in fact, create condition favorable for its growth (16). As a wound complication, the frequency of tetanus has markedly lessened since the generalization of the antiseptic treatment of wounds.

The disease has no characteristic pathological anatomical changes (that is, none have to this date been determined, or rather, demonstrated). No constant changes have been found either in the peripheral nerves or in the cerebrospinal nervous system.

The diagnosis offers no difficulties. In all forms of the disease, the chronic cephalic form excepted, the mortality is appalling. In an editorial in the Journal of the American Medical Association (16a) it is stated that "the usual rate of mortality for traumatic tetanus is probably about 80 per cent." Stewart (17) says that "the mortality is greatest in the puerperal type, extremely

few cases recovering. It is said that recovery is almost unknown in tetanus after abortion." This high mortality is due to the fact that the measures actually employed in the treatment of this disease are ineffective. It is notorious that the drug treatment of this disease has been without efficacy. Many are the medicinal agents that have been employed in the treatment of tetanus. The indication for their employment has been found chiefly in the controlling or depressing influence which they exert upon muscular action. Opium (18), carbolic acid (19), physostigmine (20), the bromides and chloral hydrate (21), can be mentioned among the drugs that have been, and still are, employed extensively in the treatment of this disease. These drugs meet, more or less successfully, isolated symptoms of this disease. Recoveries from tetanus infection are reported in which the medical attendants attribute the happy termination of the disease to the employment of one or more of the aforementioned drugs. Apparently, none of these drugs exercise much influence upon the course of severe cases. Very mild cases recover with, perhaps despite, any of the various forms of treatment.

For prophylactic and for curative purposes, antitetanic serum is widely employed. Different routes are employed to introduce the liquid serum into the human organism. The injections of the serum may be subcutaneous, intramuscular (21a), intravenous (22), intraneural (23), intracerebral (24 and 30a, Girard), or intraspinal (25). In the intraspinal method, some clinicians introduce the antitetanine in the epidural space (26); the majority, however, make the injection in the spinal subarachnoid space. In all wounds of a suspicious nature, such as those in which there is much contusion of tissue, such as are soiled with street-dirt or garden-earth, in all gunshot wounds, in wounds occurring in individuals who work around horses, in horse-shoeing establishments, or in stables, it is the practice of most surgeons to inject for prophylactic purposes in the wounded individual from 2,000 to 3,000 units of antitetanic serum. The sooner after the injury the serum is injected, the greater is its protective power, the greater is its prophylactic potency. For the last 10 years, in all individuals having wounds of the nature described above, I have injected for prophylactic purposes invariably, antitetanic serum. I have never seen a case of tetanus occur after attempted immunization. It must be stated, however,

that, lately, the immunizing properties of antitetanic serum have been disputed. Some cases of tetanus have been repeated which show that antitetanic serum is not invariably successful in preventing the outbreak of the disease. Jacobson and Pease (21a) were able to collect six cases occurring in the United States and Canada, in which, despite the previous prophylactic use of antitetanic serum, tetanus developed. In all but one of these cases, recovery ensued. Reynier (27), was able to collect from the literature thirty-one other cases of tetanus that had developed subsequently to attempted immunization by prophylactic injections of antitetanic serum. To these, he added one personal case. In this series, though the antitetanic serum did not prevent the disease, it, apparently, in most of the cases, attenuated the symptoms and positively lessened the mortality rate. Mauclaire (*Gazette des Hospitaux*, 1903. No. 43, p. 439) reports a case of tetanus, consecutive to a fracture of both bones of the forearm, due to a horse-bite. A prophylactic injection of antitetanic serum was administered, but nevertheless the disease developed. It was an attenuated form of the disease. It lasted twenty-five days. Treatment antitetanic serum and chloral. Recovery. In the lower animals, the immunizing properties of antitetanic serum have been repeatedly demonstrated. In laboratory experiments, the serum being usually injected either simultaneously with, or immediately after, the injection of the toxin, neutralization is easily effected and tetanus does not develop. Owing to the employment as a preventative of tetanus, of antitetanic serum, by veterinarians, this disease as a wound complication after castration of horses has almost completely disappeared. In the human subject, the immunizing properties of antitetanic serum are not as universally acknowledged.

As in immunizing doses, antitetanic serum is perfectly innocuous, we urge, until more light be thrown on the subject, that it be employed as a prophylactic agent against tetanus. Schwartz (30a) in 300 injections noticed no other accident but an occasional erythema (5 cases). In the opinion of many clinicians, its value as a preventive of the disease is established (30). Delbet, Demoulin (27), and Kummer (28), and innumerable other observers, have never seen tetanus develop in a patient to whom, shortly after the infliction of his injury, an immunizing dose of antitetanic serum had been administered. It must be stated, however, that

the value of antitetanic serum, as a prophylactic agent, is based on belief, on clinical observation, and not on scientifically demonstrated facts. In the Paris hospital (27) prophylactic injections of antitetanic serum were not employed between the years of 1886-1890, inclusive. During this period there were in the city of Paris, 135 deaths from tetanus. During the years 1901-1905, inclusive, the prophylactic injections were employed in nearly all if not all, the Parisian hospitals. The serum during this same period was also extensively employed as a curative agent. During the years 1901-1905 inclusive, there occurred in Paris, 153 deaths from the standpoint of tetanus development), wounds should administration of antitetanic serum, all suspicious (suspicious from tetanus.

In the prophylactic treatment of tetanus, in addition to the be subjected to vigorous and thorough antiseptic treatment. Lowering of vitality by bruising, and incorporation of foreign material, favor but are not essential for the development of tetanus. Like all sporulated microbes, the bacillus of Nicolaier offers great resistance to the action of antiseptics.

The following table is taken from an article by Scherck (29). It constitutes quite a forcible plea for the prophylactic employment of antitetanic serum.

Cases of Fourth of July injuries treated in the city dispensaries of St. Louis:

| Years | No. Cases | Antitetanic<br>serum | Death<br>from tetanus |
|-------|-----------|----------------------|-----------------------|
| 1903  | 56        | no                   | 16                    |
| 1904  | 37        | yes                  | none                  |
| 1905  | 84        | yes                  | none                  |
| 1906  | 170       | yes                  | none                  |

In the treatment of numerous cases of tetanus occurring in the human subject, antitetanic serum has been employed. In many cases thus treated, recovery ensued. It is conceded, however, that in the great majority of cases in which this agent has been used, whatever may have been the route of introduction of the serum into the human system, the results have been disappointing. The cases have terminated fatally, not on account of the administration of antitetanic serum, but because of the inefficacy of the latter as a curative agent for tetanus. So extremely unsatisfactory have been the results attending its use,



that though still extensively employed, it is regarded as inefficient by all, being employed for want of a better agent. The serum exerts but little influence on the course of the malady, and despite its use, the large majority of cases result in death.

Jacobson and Pease (21a) say, "It is apparent that after tetanus is fully established, serum therapy, however administered, promises but little as a curative agent." In a discussion before the Societe de Chirurgie de Paris (27), in which most of those present participated, the opinion was general that, as a curative agent for tetanus, antitetanic serum in the human subject is of doubtful efficacy. Calmette, himself, expresses the opinion that antitetanic serum has no curative power, but that in chronic tetanus, it markedly shortens the duration of the illness. The report of a case, in which a comparatively new mode of treatment has been employed with success, finds its justification in the fact that in the present state of our knowledge all forms of treatment, in this disease, are extremely unsatisfactory.

Mr. Otto Copeck, 17 years of age, Bohemian by birth, was admitted to the West Side Hospital on October 22, 1908. Eight days previous to admission he had stepped upon an old rusty horseshoe nail, thereby sustaining a punctured wound of the left foot. Though no attempt at disinfection had been made, this punctured wound, about an inch in depth, had by the time of admission, healed by first intention. Two days before admission, patient suffered from general malaise. On October 21st, neck began to feel stiff and sore, and patient began to experience some difficulty in opening his mouth. On the morning of October 22nd, Dr. Vasumpaur was called, examined the patient, and made a diagnosis of acute traumatic tetanus. He gave a subcutaneous injection of 2,500 units of antitetanic serum, and ordered that an ambulance be called, and that the patient be conveyed to the hospital and placed under my care. When I first saw the case, the manifestations of the disease were so classical that the diagnosis of tetanus was self-evident. There were present trismus, retraction of the head, marked rigidity of the cervical, thoracic, and abdominal muscles, opisthotonos, etc. The angles of the mouth were drawn outward and downward, the upper lip firmly pressed against the teeth, producing the facial expression which is almost invariably present in this disease. The voice was feeble. Slight disturbances of the patient, as by loud talking, opening and clos-

ure of the door, etc., would excite convulsive seizures of about 10 seconds' duration. The patient remained in the hospital 28 days. The period of convalescence began on the 10th day after admission to the hospital and was uneventful. His treatment after the first ten days consisted merely of careful nursing. During the first eight days of the active stage of the disease, patient suffered from retention of the urine. The application of fomentations to the hypogastrium having failed to relieve the condition, he was catheterized three times daily from October 22nd to November 2nd. No vesical disturbance resulted. During this same period patient was obstinately constipated. Cathartics per mouth and rectal enemata being without influence, resort was had to the subcutaneous administration of physostigmine salicylate in doses of gr. 1-100, and relief was thereby obtained. In the acute stage of the disease, two such doses were taken. In the first few days, attempts to give enemata would provoke convulsive seizures.

From October 22nd to November 2nd, inclusive, patient's diet was wholly liquid. On the evening of November 6th, he was started on semi-solid food. On the 19th of November he was discharged. During the active stage of his illness, our patient received, to combat insomnia, an occasional dose of morphine. On admission into the hospital, 4,500 units of antitetanic serum were injected in the spinal subarachnoid space, 1,500 units subcutaneously around the left sciatic nerve, just beneath the gluteal fold, 1,500 units in the region of the anterior crural nerve, about an inch below Poupart's ligament. On October 23rd, 7,500 units of serum were injected subcutaneously. On October 24th, 6,000 units were introduced in the spinal subarachnoid space. On October 25th, 6,000 units were injected in the subarachnoid space, 1,500 units in the left foot, in the region of the wound of inoculation, and the same amount around the left sciatic nerve. On October 26th, 6,000 units were injected in the subarachnoid space, and 1,500 units subcutaneously around the left sciatic nerve. On October 28th, 4,500 units were given subarachnoidally, 1,500 units in the left sciatic nerve, and 1,500 units in the left foot. On October 30th, again 6,000 units were injected into the spinal subarachnoid space, and 3,000 units subcutaneously.

All the injections in the subarachnoid space were made either through the interspace between the spinous processes of the 3rd and 4th lumbar vertebrae, or through that between the 4th and

5th lumbar vertebrae. For these injections, as well as for those aqueous solution of magnesium sulphate, anesthesia was not used. Anesthesia is not necessary. General anesthesia is decidedly harmful in these cases. It has determined deaths. Five injections, each of 5 c.c., of an aqueous 25 per cent. solution of magnesium sulphate, were introduced into the spinal subarachnoid space. The path of injection was the interspace between the spinous processes of the 4th and 5th lumbar vertebrae. The needle was inserted about 2 cm. to the side of the median line, on a level with an imaginary line extending between the highest point of each iliac crest. None of the solution was injected until a few drops of clear nonblood-stained cerebrospinal fluid had escaped.

The magnesium sulphate injections were made on the 23rd, 25th, 26th, 28th and 30th of October. Each injection was followed by marked lessening of muscular rigidity and noticeable improvement in the patient's general condition. Upon reappearance of the symptoms to an extreme degree, the injections would be repeated. After the first injection, the rigidity of the lower limbs never returned to any but a slight degree. I cannot but be of the opinion that the magnesium sulphate was a contributory factor to the patient's recovery.

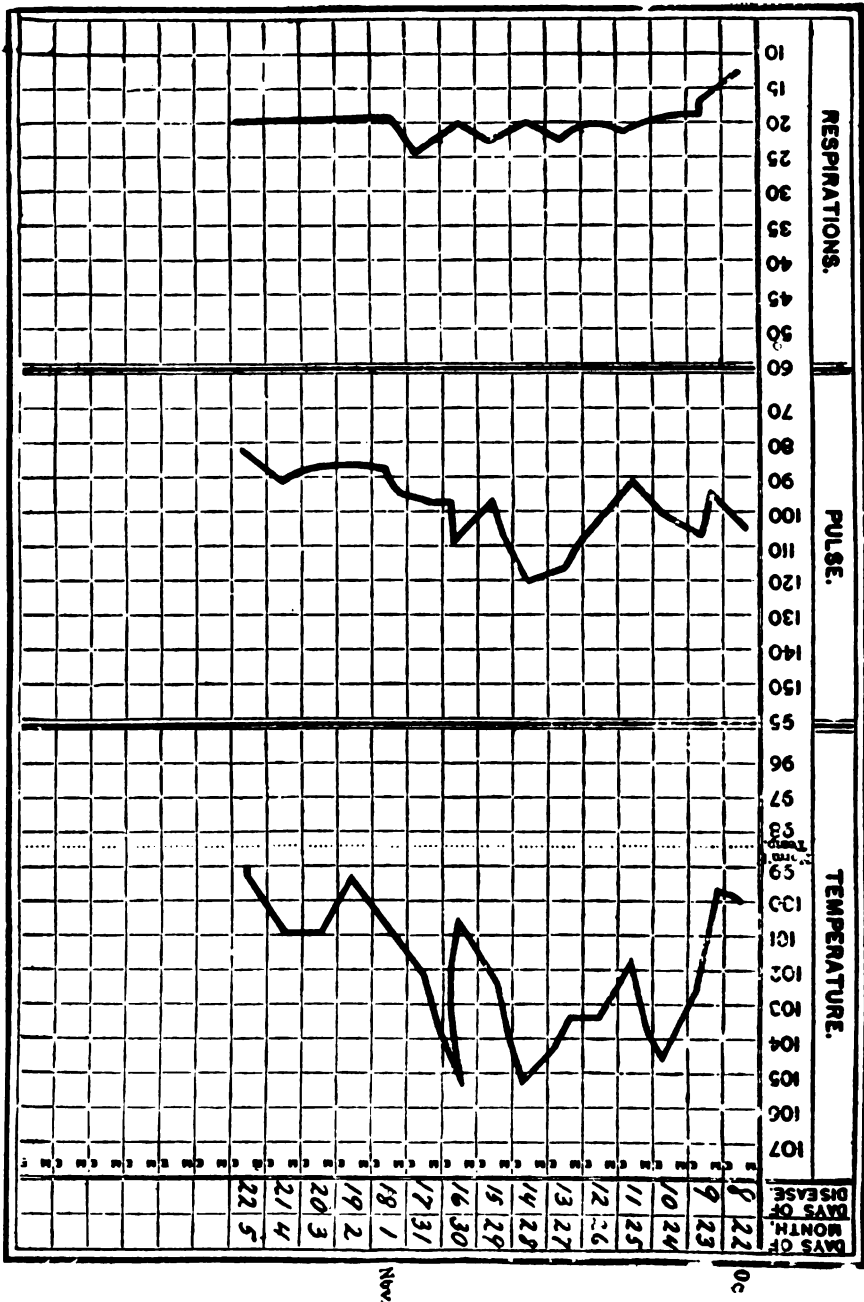
Previous to our employment of magnesium sulphate, it had been used by other clinicians. Their cases follow. In some of these cases, death occurred; in others, recovery followed. The cases as yet are too few in number for any definite opinion to be expressed as to its value. A more exact dosage must be determined. Greater proficiency in administering must be obtained. The results, however, have been sufficiently encouraging to warrant, in fact, to demand, further study of the subject. The experimental work on this subject has been done chiefly, almost wholly, by Meltzer & Auer (31). They determined that intraspinal injections of magnesium salts are capable of abolishing completely in monkeys, at least temporarily, both tonic and clonic tetanic contractions. Clinically, experience seems to partially bear out the further statement of these investigators that intraspinal injections of magnesium sulphate in doses which do not affect the respiratory center or other vital functions, are capable of abolishing completely all clonic convulsions and tonic contractions in cases of tetanus, occurring in the human subject. The

relaxing effects of the injections may last 24 hours or longer. In the case which I report, none of the vital functions were influenced by the intraspinal injections of magnesium sulphate. In some parts of the body, such as in the lower extremities, the muscular relaxation following upon the injections was complete. In other portions, such as the mandibular, facial, or cervical muscles, the rigidity was very much lessened, but it was not completely overcome. Was it due to insufficient dosage, I am unable to state. Appended to the article is a temperature, pulse, and respiratory chart, in the perusal of which it will be seen that the injections at times were followed by an elevation of temperature. This has been noted by other observers. In Miller's (33) case, the injections determined a profuse secretion of mucus, bronchorrhea, at times severe enough to embarrass respiration, but easily controlled by atropine. Was there a relation of cause and effect between the injections and the elevation of temperature? This must also be decided by further study of the subject. Meltzer and Auer (32) have determined that when administered by the intravenous route, the magnesium salts are very toxic, and that even small doses completely inhibit the respiration. Therefore, for the administration of these salts, this route, the intravenous route, should never be employed. We employed the agent only in the shape of injections in the spinal subarachnoid space.

In all of the tabulated cases, the magnesium sulphate was injected in the subarachnoid space. The solution has also been used subcutaneously in the following three cases.

Lyon (35) reports the following case: Male, 7 years, stepped on a nail which entered left foot after perforating sole of his shoe. It barely penetrated the skin. Wound scarcely noticeable. Eight days later, complained of stiffness of foot and of leg. Convulsions on the 9th day. On the 11th day, the jaws were set and almost all of the muscles were rigid. The wound was opened and treated with peroxide of hydrogen and tincture of iodine. Morphine, chloral, and bromides partially controlled the convulsions. On the 12th day, 2 drachms of magnesium sulphate in 4 oz. of distilled water, were injected under the skin of the abdomen. At end of 2 hours, jaws could be opened 2 cm. Muscles were markedly relaxed. On the 13th, 14th, 17th and 19th days, the magnesium sulphate injection was repeated. The convulsions had become infrequent and mild. Twice, there was bron-

# A CASE OF TETANUS.



Second line of figures indicates the day of onset of symptoms.

chorrhea. A vesicular eruption covering the whole body appeared on the 14th day. The vesicles were pin-head size and were filled with a clear fluid. In a week, these dried up and disappeared with exfoliation of the epidermis. Digitalis necessary to improve heart action after first week. During the patient's convalescence, tonics were given for the anemia. Able to sit up on the 30th day. Walked as usual in about 10 days more.

Greeley (36) employed, with success, magnesium sulphate in aqueous solution in two cases of tetanus. As his mode of administration was the subcutaneous, we will briefly mention and not discuss them. The first case occurred in a boy 2 years old. The child had stepped on an old garden rake and lacerated the web between the great and the adjoining toe of the left foot. After an incubation period of 10 days, the symptoms appeared. Greeley administered 7,500 units of antitetanic serum. In addition, every 2 hours, 5 grains each of chloral hydrate and of potassium bromide were administered. By hypodermoclysis, one pint of distilled water containing 2 drachms of magnesium sulphate were introduced into the organism. This was repeated on the next day. Recovery followed.

Greeley's other case was one of chronic tetanus. Four weeks elapsed between the inoculation and the outbreak of the symptoms. By hypodermoclysis, 3 drachms of magnesium sulphate dissolved in a pint of distilled water were introduced into the organism. Recovery ensued.

Wm. Hessert (34) a few weeks ago showed to the Chicago Medical Society a case of acute tetanus successfully treated with subarachnoid injections of an aqueous 25 per cent. solution of magnesium sulphate.

We cannot, and we are unwilling to, make any statement as to the value of magnesium sulphate as a therapeutic agent in the treatment of tetanus. The cases in which this agent has been used, are, as yet, too few in number to allow the expression of an authoritative opinion. Further laboratory experiments and numerous clinical reports are needed. The animal experiments conducted by Cruveilhier (37) are too few to be conclusive. His findings are contracted by clinical observers. We would refer the reader to appended tables. The faith which Cruveilhier reposes in antitetanic serum as a curative agent is not warranted by the results that this agent has yielded.

(TO BE CONTINUED).

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"TRICKS IN ALL TRADES BUT OURN."\*

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BY ARTHUR G. HOBBS, M. D., ATLANTA, GA.

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The doctor's tricks, in his consultation room or at the patient's bed-side, are for the patient's good and not for the druggist's emoluments. There is a prescription problem, however, that the doctor must solve for his patient and with his druggist. And may we not go still farther? Is it not a fact, a truth, that almost all patent medicines, and many proprietary formulas, are directly or indirectly purloined from some doctor's prescription, sent in good faith to his druggist, to meet a special, and not hypothetical, or imaginary ills.

A prescription is only an instruction to the druggist for the patient's present needs. It is not an order for all future time; and yet the patient, in his ignorance or haste, will vie with the druggist's cupidity to the detriment of the one, and to the small gain of the other.

An order for any other commodity would not be duplicated. But should it be, the loss would only affect the purse, and not the physical well being of the patient.

All doctors write prescriptions, sometimes, that are only placebos when they find nothing else indicated; what intelligent doctor could do otherwise? And shall I say, "by the way?" No; because the following interpolation is apropos: Upon this rock—the application of the immemorial place—be of all true doctors—is founded the so-called Christian Science Treatment. This cult assumes that there is nothing potential in therapeutics; nothing sillier, nor that there is any good in surgical assistance; nothing more absurd. Is this delusion altogether mental? "Pity 'tis, and pity 'tis, 'tis not true." But a little "knowledge does often make mad," especially when applied to medicine, the science of all sciences that has made the greatest strides during the last two decades.

But to return to the caption of this paper. The doctor's tricks are altruistic and not egotistic—for the patient's good only. When we make a prescription of potency, with a power for good, or if misused, for evil, we naturally do not always want it refilled, neither for the patient's possible detriment, nor for the drug-

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\*Prepared for Fulton County Medical Society.

gist's gain, nor yet for the patent medicine vampire's vaunting.

Then, how are we to meet this emergency? Suppose we use an *Evanescent Ink* in the body of the prescription to last for a week only? The doctor's and the patient's name can be written with the ordinary pen, which will hold fast. But when the druggist is called upon to refill No. 4711 he finds a blank. He wonders why, but he has nothing else to do but to see, or 'phone the doctor before he can refill the prescription, and learn whether or not he should.

The druggist is human, like all of us; he wants a dollar's profit, more or less, from the returned prescription; the doctor will never know, and the patient thinks he has the right to demand its refilling.

This question, as to the rights of the doctor's prescription, has not yet been settled as it should and must be for the patient's good.

The foundation of all patent medicines rest right here, and, most all proprietary medicines are so based. As the refilling goes on and on, and like an endless chain, the *R* is handed down from one to another. The natural suggestion to the druggist is, Why not make the *R* a patent, or, else turn it into a proprietary formula?

If we should write on our prescriptions: "Not to be refilled," it takes much time, with the average patient, to explain why this sentence was necessary. But, even the patient will probably disregard it, and the druggist will overlook it, when he finds his stipend is at stake.

The ordinary patient's idea is that a doctor's prescription, once delivered, is a fee-simple title to its perpetual use, whether paid for or not. This is without regard to the good or bad results that its refilling might bring about.

Then why should we not use an *evanescent ink* when we write a potent prescription, for the patient's and for our own good? It is easy to do. It will keep us in touch with our patients, and them with us.

I will suggest a crude formular of an *Evanescent Ink*:

|                  |           |      |    |
|------------------|-----------|------|----|
| <i>R</i> —Iodine | — — — — — | grs. | 5  |
| Iodide Pot.      | — — — — — | grs. | 5  |
| Mucil Acacia     | — — — — — | dra. | 2  |
| Aqua add to      | — — — — — | oz.  | 22 |



Mix and use with an ordinary pen on well glazed paper.

But there are many other and probably better evanescent inks to be found at the book stores, and in some drug stores.

Then if "there are tricks in all trades but ourn," may not any true doctor resort to this one for his patient's good?

805-7-9 English-American Building.

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### COMMENTS ON TWO RECENT CASES OF GASTRO-ENTEROSTOMY.\*

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BY EDWARD G. JONES, M. D., PROFESSOR OF SURGERY ATLANTA SCHOOL OF MEDICINE.

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While the cases I shall report suggest a discussion of many of those interesting questions connected with gastric surgery, they are presented as illustrative of two points particularly:

(1) The usual curability of chronic gastric and duodenal ulcers by surgery as compared with their usual incurability by medical means, and

(2) Our present inability to predicate the exact character of the lesion in certain cases of gastric hemorrhage.

It may be recalled that, in reporting some cases of gastro-enterostomy, I presented before this Society last May, a man operated on for chronic gastric ulcer a year ago. He remains entirely well, has no uncomfortable symptoms whatever, and has gained 50 pounds.

I.—Chronic Duodenal Ulcer. Male, age 29. Family history unimportant. Indigestion for 15 years. Five or six years ago attacks were periodic, lasting from one to three weeks; now patient always suffers at least epigastric discomfort if enough is eaten to satisfy appetite. On this account he constantly under-feeds. Six weeks before coming to me he had Hematemesis; one year before he also vomited blood. Following both the attacks of hematemesis and also on perhaps a half dozen other occasions during the past three years, the attacks of Melena were observed. Patient complained of Hyperacidity, takes soda and avoids pickles, lemons, tomatoes, etc., because he has learned that

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\*Presented before the Fulton County Medical Society, December 3, 1908.

such things induce a "boiling" sensation in his stomach. He frequently wakes after midnight or early in the morning feeling that he must regurgitate a sour collection in his stomach. If he is able to do this he feels relieved; if not, his distress continues. Because he had had a comparatively recent attack of hematemesis and had never taken the tube it was thought wise not to confirm these presumptive evidences of hyperacidity. His teeth have been eroded and "worn to the quick," probably by acid eruptions. The distress is more of a epigastric tenderness than actual pain. It is relieved to a great extent by vomiting, though patient has learned that the necessity for vomiting may be avoided to a great extent by taking small amounts of food. Flatulence is not constant, but common. The patient is thin and anemic, and his general discomfort is such as to incapacitate him for work. Examination by cautious dilatation of the stomach (?) revealed no evidence of pyloric stricture.

A diagnosis of gastric or duodenal ulcer was made. The sex, the frequent attacks of melena as compared with hematemesis, the incidence of distress after midnight, the prior periodicity of the attacks suggested duodenal location.

Operation revealed an ulcer scar, indurated and whitish, just beyond the pyloric vein, and having a base comprising about a square inch. The scar being anterior, Finney's duodenostomy was decided against and posterior gastro-jejunostomy was done. The meso-colic band was long and pulled the beginning jejunum toward the median line. It was snipped with scissors and the anastomosis established in the oblique line, commonly followed by the Mayos. Moynihan and Mayo Robson, under these circumstances, make the stomach incision vertical, believing that when the jejunus thus takes a course directly downward, there is less danger of troublesome kinking of the gut.

The patient recovered promptly, and has been entirely relieved of his previous discomfort. A report two months after operation says that he feels better than he has in years, and has gained 29 pounds in weight. He has not vomited since the operation—not even from the ether.

Given a diagnosis of gastric ulcer supported by a first attack of hematemesis, will the patient usually be cured by medical treatment? And by the term "cured" is not meant merely the stopping of the hemorrhage; as a matter of clinical history, we

know that the hemorrhage will commonly stop at least temporarily. But does the patient, or does he not, continue to suffer with intermittent or constant dyspepsia, epigastric discomfort, "heart-burn," flatulence, etc., and does the hemorrhage, if there have been hemorrhage, recur after weeks or months?

That in the majority of instances such patients will not be cured by medical treatment alone; a multitude of authorities, both medical and surgical, might be called to witness. Bulstrode, in 1902, analyzing 500 cases, admitted to the London hospital, concluded that at least two-fifths of these patients (who had been treated medically) were suffering from recurrences or relapses—and these figures did not include patients who came in suffering from the complications and sequelae of ulcer. Paterson traced a series of 72 cases treated medically, and discharged as cured. He believes that at the time of observation all but 10 had (a) suffered from one to four recurrences of hematemesis, or (b) died of hematemesis or of some other accident traceable to the stomach lesion. Moynihan maintains that the percentage of permanent cures of gastric ulcer medically treated is under 25. Mayo Robson believes that at least half of all patients suffering from stomach ulcer and treated medically, ultimately succumb to the disease or one of its complications—without reference to the considerable number of persons so affected who lead more or less miserable lives and fall victims to other maladies because of their lowered vitality.

Does latter day surgical treatment of these lesions offer any more encouragement than is contained in the above reports? In answer to that question I submit the following:

Mayo Robson, reporting upward of 300 cases treated by gastro-enterostomy, has had a mortality of a little above one per cent.; and more than 90 per cent. of his patients so treated remained completely relieved of all symptoms up to the time of his report, which covered about five years.

The Mayos report this year "of the 318 actually demonstrated ulcers, we have traced 234. 80.7 per cent. are cured; 9 per cent. are improved; 4.2 per cent. are unimproved; 6 per cent. have died since operation for various causes (but in only two of these deaths was the stomach concerned.)" A total of 89.7 per cent. were, therefore, cured and improved.

While the actual statistics of Moynihan are not at hand, it

is known that his experience is practically the same as that set forth above.

It is especially to be remembered that these statistics include the early as well as the recent cases of these surgeons; it is the early cases which furnish the failures to a very large extent because these men had to work out the proper technic of the operation themselves. Certain it is that any criticism based upon the inclusion in their statistics of cases operated on too recently to be yet classed as cured is more than offset by the experimental nature of their early experience.

We may, therefore, conclude upon ample evidence that surgery which a few years ago was invoked only to treat the sequelae of stomach ulcer, (stricture, perforation, hemorrhage, etc.,) may now properly be invoked to cure the indigestion traceable to the ulcer.

2.—Multiple Acute Ulcers. Female, age 53. On November 19, 1908, suffered with a severe attack of hematemesis. She was seen by Dr. Dorsey soon afterward. She rallied well under appropriate medical treatment. On November 21, she suffered another attack of hematemesis, vomiting perhaps, three pints of blood. I saw her two hours later, with Dr. Dorsey. She was blanched and in collapse, this state of collapse having come on with the hematemesis—not gradually before vomiting began.

It was not through that the patient had a ruptured aneurysm; she was not arterio-sclerotic; there was no enlargement of the liver or spleen; there was no history of hemophilia or vicarious menstruation; nor was there any previous history characteristic of chronic ulcer except a possible hyperacidity and an indefinite legend of melena just a year before. The rally after the first hemorrhage, the somewhat sudden appearance of collapse with the second hemorrhage, the fact that perhaps the major portion of blood vomited on both occasions was not clotted, but liquid, and the history of possible melena led us rather to believe that there had been erosion of a vessel of some size in connection with an old ulcer instead of capillary oozing.

It was decided to wait in the hope that the patient would rally. Twelve hours later, however, when there was little evidence of improvement in the woman's condition, it was decided to operate in the hope that a controllable lesion might be discovered and properly handled.

The abdomen having been opened, the stomach was hastily examined externally for an ulcer site which might be excised or otherwise properly treated. No lesion being apparent, the stomach was opened. A quart of blood was quickly removed, mostly clotted. Upon close examination of the mucous membrane, numerous small points having a diameter of one-fourth inch and downward were discovered from which blood slowly oozed. Unfortunately the welfare of the patient prohibited a close study of any of these areas, but the impression was the same as if the epidermis had been brushed off by some light blow and capillary bleeding had come on in a few seconds. No extensive lesion being found, it was apparent that the hemorrhage had its origin in these small areas. The condition of the patient being very precarious, no time was lost to discover how many such bleeding points could be found. Not less than a half dozen, mostly on the posterior surface but involving also the anterior wall, were easily seen. In addition there were seen numerous small hemorrhagic "punctate spots" where blood had apparently clotted in the small vessels, and where one would believe that hemorrhage had previously taken place, but had now stopped.

It being manifestly impossible to control the bleeding by direct treatment, the stomach was closed and a posterior gastro-jejunosomy quickly performed. The patient was returned to bed practically pulseless, though the operation has been short. In travenous infusion of saline was begun concurrently with the laparotomy. Saline per rectum, together with the usual methods of stimulation, were continued after she was put to bed. The patient died, however, four hours afterward, not having vomited blood meantime.

While it is not intended to bring within the scope of this report the question as to when, if at all, it is advisable to operate for gastric hemorrhage, it is not out of place to say that in this instance the practice of the highest authorities was followed. It may also be said that no operative procedure except a gastro-enterostomy could have commended itself in this case; but I believe that an early gastro-enterostomy would stop hemorrhage from these lesions by emptying the stomach (thus relieving the stretched mucous membrane) and by setting it entirely at rest. Indeed clinically this procedure alone has proved so efficacious

in stopping hemorrhage that Mayo Robson and Moynihan state that they seldom feel called upon to do anything else (surgically) to stop gastric hemorrhage. However, in waiting the advice of excision or direct ligation, or any other such measure is adopted they invariably supplement it with gastro-enterostomy to secure rest.

To me it appears that if in this instance we had operated immediately after the first hemorrhage we would probably have saved the woman's life—basing this belief on what is said by experienced clinicians about the competence of gastro-enterostomy to stop gastric hemorrhage. However, in waiting the advice of all authorities, medical and surgical, was complied with, and under the same circumstances with the same light I would wait again.

With reference to our foreknowledge of the character of the lesion in this case, it may be said that a large unheralded spontaneous gastric hemorrhage most usually betrays one or the other of the several lesions commonly catalogued as acute ulcer, but gives little information as to whether there is capillary oozing from one or more areas or bleeding from a comparatively large vessel. Mayo Robson says: "Capillary hemorrhage may be so free as to render it difficult to say that some large vessel has not given way, yet after death a careful examination may fail to discover any gross vascular lesion \* \* \* Arterial bleeding is mostly responsible for the serious and fatal hematemesis from gastric ulcer." But the same author adds, "In the present state of our knowledge it is impossible to diagnose the size of the vessel perforated, either from the amount of blood or the length of survival \* \* \* If, therefore, medical treatment and rest properly carried out are not successful in arresting the bleeding in a few hours, or if after being arrested it recurs, we should be driven to the conclusion that a large vessel is perforated."

205 Fourth National Bank Building.

#### DISCUSSION OF DR. JONES' PAPER.

Dr. Dorsee said that melena as a symptom was far more likely to indicate piles than gastric ulcer. Hematemesis was not clearly diagnostic, because in one of his cases the blood did not all sink in water; it seemed too fresh. Pulmonary signs were lacking and bile followed the bleeding, which showed the gastric source.

He described a case of hematemesis in pregnancy occurring at third or fourth month of pregnancy three times. She aborted twice and recovered perfect health twice. She is now pregnant and vomiting blood the third time. He asks when he shall operate on the stomach.

Dr. Barnett related the case of a man thirty years old who passed large amounts of blood by the mouth and rectum. He had no pulmonary trouble and no blood disease. He had had two attacks of malaria obscure in history. Seemed in good health. Had three or four hemorrhages in past three years increasing in frequency. He died without operation. No post-mortem could be obtained.

Dr. Strickler said there was no evidence of leukaemia in the previous case. He had examined the blood personally.

He believes that all these cases should be treated surgically if medicine doesn't give immediate relief.

He was most unhappily impressed by a case of classic duodenal ulcer. The man improved under treatment and was apparently doing nicely for several days. He called on the doctor hurriedly one day and collapsed. He died in an hour from shock.

Dr. Duncan said that soda was greatly abused and even dangerous household remedy, because it was so often taken to neutralize hyperacidity when it really increased this condition.

Dr. Clark asked Dr. Barnett as to the temperature in his case. Dr. Barnett said it was slightly subnormal most of the time, though once it ran to 100.

Dr. Cartledge asked Dr. Jones if one of the cases he described in which a mother had been nursing a tuberculous son could be pulmonary in origin.

Dr. Jones replying, said there was no evidence of pulmonary difficulty.

Speaking of the technique of the operation, he said: the jejunum may go to the right or to the left or directly downward and the line of the posterior incision in the stomach should correspond to this varying direction however it might be in each individual case.

The majority of ulcers are really in the duodenum. The pouching of tissues makes it appear in the stomach, when really it is further down.

## AESTHETIC ALIMENTATION.

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BY GEO. M. NILES, M. D., ATLANTA, GA.

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"How Near to Good is What is Fair."—*Ben Jonson.*

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This title was suggested by a recent editorial in a New York medical journal, arousing the thought that a discussion on the benefits of seeking the beautiful and alluring in eating might be of both interest and profit.

It seems a far cry from John the Baptist, eating locusts and wild honey in the wilderness, to Lucullus, the most princely entertainer of his age; from the rude customs of the Goths in the third century, to the refined doctrines of Omar Khayyam, the material Epicurean of the twelfth century; or from a tramp, with grimy hands, eating a "hand-out" on the back steps, to a Bradley Martin banquet.

These contrasts represent evolution, education and civilization.

But who would gainsay the assertion that John the Baptist would have better enjoyed a tempting meal under a sheltering roof? That the Goths would have been susceptible to some of the amenities of dining? or that the humble tramp would have partaken of his simple repast with greater relish from a clean plate and with clean hands?

Those who eat to live, and those who live to eat are the extremes. They are not representative.

The lunch-counter fiend, who bolts his dinner in five minutes, and the disciple of Horace Fletcher, chewing his food until it is imperceptibly swallowed, are two other extremes. Neither gets the highest pleasure from eating.

It is necessary that we should eat. Fuel must be furnished our bodily furnaces that a proper temperature may be maintained through the vicissitudes of heat and cold. The adult must have enough nourishment to provide energy for the various functions, voluntary and involuntary; while the growing child requires a surplus commensurate with increase in weight.

An active individual cannot care for as much food during an enforced rest, while, in a normal convalescence from wasting disease, the appetite is insistent in its demands.



Now, let us get to the point: As the boy, whistling on his way to school, finds the journey shortened thereby; as the laborer in the field, or the busy housewife in the home finds that singing and cheerfulness lighten the task and speed the hours, so we can apply and elaborate that principle as an aid to that great multitude suffering from capricious appetites and faulty digestion.

The science of the beautiful can deal with actual phenomena, with facts as hard, with rules as fixed and laws as inflexible as do the sciences of biology and physics.

There lies within every intellect, no matter how uncultured, an inherent love for the beautiful. Even the man who can see naught savoring of poetry in "A primrose by a river's brim," has a tuneful chord somewhere within his soul, if it can only be vibrated.

Everybody knows how anger, grief or worry will destroy the desire for food as well as interfere with its digestion.

The writer once saw a cat subjected to an X-ray after being fed. She was quietly stroked until she began to purr, and her stomach could be plainly seen moving in rhythmical waves. In a few moments her tail was pinched, causing a profane outburst of indignation on her part. Immediately all motion of the stomach stopped, nor was it again resumed until she was pacified.

We know how savory odors make the mouth water, and how a tempting array of well-cooked viands suitably garnished pleases the eye; but we do not fully realize how potent the effect on the digestion is the appeal to the aesthetic in our nature.

Under the charming influence of a good meal, tastefully served, where individual fancies are consulted; where there is neither hurry nor tiresome delay; where all the externals that make for beauty are present, and where cheerful conversation rules the board, the digestive organs are at their best. Under these benign influences the vaso-motor nervous system relaxes the arteries furnishing blood to the alimentary tract, a plentiful amount is provided, allowing all the forces that supply our needed energy and heat to perform their functions efficiently.

The expensive dinners, embodying culinary symphonies by high-priced chefs, where the aesthetics are represented in every detail, are within the reach of only a few; but to some extent an appeal to the aesthetic in alimentation is within the reach of all.

This fact the writer wishes to stress: that the cultivation of not only the substantial phases of energy and thought, but also the flowers of energy and thought will benefit the mind, the character and also the actual working forces of digestion governed by our sub-consciousness.

A recent writer has said: "There is no tonic so uplifting and renewing as joy, which sets into active exercise every constructive power of the body." So, when suitable food is provided and served, attention to little details which go to make it attractive is time well spent.

Let me insert this simple illustration. Every one will admit that tea served in an egg-shell china cup on a dainty cloth tastes better than if it were in the thick, yellow cup, bearing the scars of rough usage, and poured from a cracked teapot. We may be thirsty and faint, and drink it down from sheer necessity, but something within us revolts, and we do not get the full benefit of it.

The novelists have stirred our emotions with prose; the poets have reached our inner natures with their verses; the painters have uplifted us with their creations of form and color; while the musicians have borne us away on a sea of harmony and melody.

The writer of this article, in an humbler, but fully as important theme, appeals to the senses that lie at the very foundation of our living. He appeals that in furnishing the needed nourishment, it be not shoveled in like coal into a furnace, or poured like corn into a hopper, but that the amenities and aesthetics of civilization be observed. Thus will we not only assist those sub-conscious forces, which work silently and faithfully, to give us their best fruits, a healthy mind in a healthy body; but we will also help onward that evolution of the aesthetic, which is the duty of every enlightened nation.

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Getting Him Classified.—"What sort of an after-dinner speaker is Bliggins?"

"One of the kind who start in by saying they didn't expect to be called on, and then proceed to demonstrate that they can't be called off."—*Washington Star*.

# EDITORIALS

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## DEATH OF DR. W. B. ARMSTRONG.

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It is with a feeling of unusual sorrow that we chronicle the untimely death of Dr. William Buckingham Armstrong, one of Atlanta's most successful and loved young physicians. Dr. Armstrong died of pneumonia complicating chicken pox, February 2, at his home, aged 35. His death is a great loss to the medical profession of this city, and the Journal-Record of Medicine and its staff extends deepest sympathy to his bereaved relatives and friends.

Dr. Armstrong was born in Atlanta in 1874, and here he received his preliminary education; his collegiate course was taken at the University of Georgia, where he was graduated in 1894. He was a member of the Chi Phi fraternity. Like his illustrious father he determined upon medicine as his avocation and entered the College of Physicians and Surgeons, New York, from which school he was graduated, with honors, in the class of 1899. After several years service in the New York hospitals, Dr. Armstrong began the practice of medicine in Atlanta, where he met with notable success. He was soon made associate professor of Anatomy in the Atlanta College of Physicians and Surgeons, and was appointed upon the visiting staff of the Grady, Presbyterian and Wesley Memorial Hospitals; he was also serving upon the local board of health at the time of his death. Dr. Armstrong was a careful, conscientious worker and his services were held in high esteem by all of patients; he also took much interest in the scientific part of medicine and was a regular attendant

and interested member of the Fulton County Medical Society and the Georgia Medical Association.

In 1901 he married Miss Ruby Dart, of Brunswick, Ga.; he left one son less than three years of age.

As worthy citizen, a lovable physician, a devoted father and husband, Dr. Armstrong's loss will be keenly felt, and in the hearts of us all his place will long be held dear.

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### EXAMINATION OF SCHOOL CHILDREN.

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Regarding the feasibility and advisability of making regular physical examination of all school children, the Committee of the Fulton County Medical Society appointed to make an investigation of the matter, made the following report which was unanimously adopted:

That all school children should be examined for the presence of contagious and other diseases.

That all examinations should be made by physicians, or under their direction.

That the examining physicians should be general practitioners of medicine, and not specialists.

That such examining physicians should be elected on competitive examination to be given by the medical members of the City Board of Health, and the President of the Fulton County Medical Society.

That the examining physicians should devote all their time to this work, not be allowed to do any private practice or treat any case whatsoever, shall accept no remuneration other than is here specified, or shall in no case advise concerning what physician shall treat any case.

That they be elected annually.

That the Examining Committee shall have power to reappoint the physicians annually if their services have been satisfactory.

That any examining physician, desiring to resign should give three months' notice.

That the examining physicians shall consist of the requisite number of physicians who shall be paid each, \$1,200 per annum, and that they shall be under the control of a joint committee from the Board of Education and the Board of Health, with the health officer of the city as direct superior.

That the city medical officer make a complete report to the Board of Health once a month.

That each examiner be required to keep a card index system, showing the condition of each child's examination, and shall make a written report to the city medical officer.

That no report of the child's condition can be received unless the examination of the child has been made by the authorized examiner of the school where the child attends.

We believe that it would be inexpedient for the city physicians to undertake this work of examining the school children.

That a corps of nurses, sufficient for the needs of the service, should be employed to assist the physicians.

That these nurses should be selected in the same manner as the examining physicians. They shall not advise concerning what physician shall be consulted by any child.

That the teachers also, be examined annually, and shall also be under the supervision of the medical examiner.

That teachers should be included in the examination.

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## GASTROPTOSIS IN TUBERCULAR PATIENTS.

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The writer has recently read with much interest a paper in the South California Practitioner, in which Dr. Boardman Reed, of Los Angeles, and Dr. Frank Robinson, of Monrovia, discuss the question of gastroptosis in tubercular patients.

Just now, when tuberculosis in both its medical and sociologic aspects is being so keenly studied, any thoughtful expression from a competent observer will receive due weight.

In this paper there are 221 tubercular patients reported on, the time of observation extending over about fifteen months. Of this number, 108 were men and 113 women. Of these, 133 show-

ing pronounced gastro-intestinal symptoms, their abdominal organs were carefully examined.

Out of the above 133 cases 50, or 37 per cent., showed more or less gastropotosis. Of these 50 cases, 28 were women and 22 men. Ten of them showed also movable right kidney, 9 being women.

This report would bring up the following questions: Was the presence of gastropotosis in such a number of coincidence; was it to any extent a causative factor; or did it follow in the wake of the tuberculosis?

Charles R. Stockton, in a paper appearing in 1900, writes as follows: "The fact that more than 50 per cent. of all civilized women in all classes of life have developed the condition known as enteroptosis, which means that the stomach and intestines, very often the kidneys, and sometimes the liver are dragged down and remain permanently out of their position, is not generally known. Such, however, is the case; and this condition more than any other cause is responsible for the constipation, backache, debility, biliousness, early loss of complexion, headache, and that long list of ailments of which so many women in all civilized countries are victims."

Einhorn, in 1901, reported on 1912 patients, 347, or 18 per cent. of which had splanchnoptosis including gastropotosis. Of these 70 were men and 277 women.

The writer's observation has led him to believe Stockton's estimate rather high for the present time, and Einhorn's rather low; the term *present time* being used advisedly, for the straight-front corsets now worn are certainly less liable to cause downward displacements than those of eight or ten years ago.

The conclusions of Drs. Reed and Robinson would indicate that the ptoses could only be regarded as predisposing factors. Many of the tubercular lesions were recent, while the ptoses showed evidences of long standing.

We can easily see that the disturbances of metabolism incident to gastropotosis would render the patient less able to resist the inroads of the infection. It would also naturally affect the system of forced feeding so heroically carried out by some; and would explain why some of the cases failed so utterly to respond to a generous diet.

The following is quoted from the paper mentioned, and is

endorsed by the experience of the writer: "At all events our observation has proved that overcoming any coexisting visceral displacement has been followed by a better response to the essential curative measures for the principal disease."

"In all known tubercular cases, therefore, we should search for and correct any existing visceral displacement as a very helpful preliminary to the cure of the major disease; and to prevent the development of tuberculosis in persons predisposed thereto by reason of lowered nutrition, the same precaution is equally important."

A careful examination of the abdomen, therefore, should never be omitted in these cases, for when a visceral displacement, especially a gastropptosis is found present, there will necessarily be a change in the dietetic and mechanical features of the general management of the patient.

G. M. N.

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## THE PHYSICIAN AND BROUGHTON—EMMANUELISM

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Much of the early history of medicine is intimately associated with the church, in fact during certain periods of the dark ages the church was the chief custodian of medical knowledge. Nearly 800 years ago, under Pope Calixtus II, the practice of medicine and the church were "forcibly rent asunder;" that we will again retrograde to a re-union seems exceedingly unlikely. The emmanuelists are attempting to make such union, however, and purpose to use the physicians as tools for making diagnoses while they delegate to themselves the right to treat the patients, assuming superior knowledge in such matters. It does not seem unreasonable to take the ground that the doctor—knowing more about diseases—is legitimately entitled to carry out the treatment.

Psychotherapy has been an important method of treatment from time immemorial as medical literature shows; we have books devoted exclusively to this form of treatment and, while

not heralding our results with it before the lay world any more than our cures of syphilis with mercury, it demonstrates our familiarity with such measures. It seems, now, rather preposterous for a few ministers, who have recently become interested in psychology to allow their enthusiasm to so exceed reasonable bounds that they consider themselves more competent to wield psychotherapy than physicians who are vastly more familiar with disease and, as a class, understand psychology equally as well or better than ministers. We further think they are unjust in arrogating to themselves all of the "cheerfulness, hope, courage, faith and praise."

That some physicians are not as conversant with psychotherapy as they might be, may be granted—the same might be said, however of all therapeutic measures as well urinalysis and all diagnostic methods. The church can be a powerful agent in waging a warfare against disease by inculcating principles of right living, optimistic thinking, cleanliness and morality; in the actual treatment of disease itself the physician who makes it a special study is the one to whom such should be delegated.

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### STATE SANITARIUM FOR CONSUMPTIVES.

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Governor Smith has appointed the board of trustees for the state sanitarium for the treatment of tuberculosis and it is believed that the institution will soon be in operation.

At the last session of the general assembly an appropriation of \$25,000 was made for the establishment of this institution, of which \$1,000 was made available in 1908, and \$12,000 in each of the succeeding years. This means there is now \$13,000 available with which to begin the work, and the future of the project is now in the hands of the trustees.

The trustees may purchase a tract of land and provide for the erection of a building, or they may buy a building already erected and begin work at once. The details are entirely within their hands. It is probable that a meeting will be called at an early date and following organization a location will be secured.



Following is the board of trustees named by the governor consisting of two from each congressional district:

First Congressional District—Dr. P. S. Clarke, of McIntosh, and Hon. C. W. Skinner, of Burke.

Second District—Dr. E. Daniels, of Colquitt, and Dr. R. C. Woodward, of Berrien.

Third District—Dr. C. H. Richardson, of Macon county, and Dr. J. R. Statham, of Sumter.

Fourth District—Dr. H. R. Slack, of Troup, and Hon. W. B. Short, of Marion.

Fifth District—Hon. W. G. Raoul, of Fulton, and Dr. T. R. Whitley, of Douglas.

Sixth District—Hon. T. D. Tinsley, of Bibb, and Dr. M. F. Carson, of Spalding.

Seventh District—Dr. C. F. McLain, of Gordon, and Hon. J. D. Anderson, of Cobb.

Eighth District—Dr. W. I. Hailey, of Hart, and Hon. J. D. Harvey, of Jasper.

Ninth District—Dr. Jeff Davis, of Stephens, and Hon. M. S. Cornett, of Gwinnett.

Tenth District—Dr. W. B. Crawford, of Lincoln, and Hon. T. I. Hickman, of Richmond.

Eleventh District—Dr. J. A. Butts, of Glynn, and Dr. W. H. Born, of Telfair.

The terms of office of the appointees are four years and they are to have entire authority in the location, establishment and management of the new state institution.

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## NEWS AND NOTES

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Dr. Hugh M. Lokey, who has been associated with Dr. A. W. Calhoun since 1902, has opened offices at 412-13 Candler Building. He will confine his practice, as heretofore, to the diseases of the eye, ear, nose and throat.

Dr. E. C. Davis left recently for a trip to Panama and South America.

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Dr. J. S. B. Holmes, formerly of Atlanta, but now of Valdosta, spent a few days with friends in Atlanta a short while since.

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Dr. Wm. T. Bull, the noted New York surgeon, died in Savannah, February 22nd, after a prolonged illness.

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The many friends of Dr. Yankee will be glad to learn that he is doing nicely since his recent operation of appendicitis.

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Dr. W. C. Bryant has given up his practice in Atlanta and has entered a new field, locating at Pittsburg, Pa. During his short sojourn in Atlanta, Dr. Bryant made many friends who will regret to learn of his decision to permanently locate elsewhere.

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Dr. John B. Deaver, of Philadelphia was a guest at a very delightful and unique dinner in Philadelphia on the night of the fifteenth. The occasion was the gathering of those members of the medical profession upon whom Dr. Deaver had done some major operation.

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Dr. J. H. Bradfield was elected to the Atlanta Board of Health to fill the unexpired term of Mr. Erskin. (Resigned).

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Dr. and Mrs. J. Edgar Paullin are at home to their many friends on Peachtree street, Atlanta.

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Dr. John McArden Johnstone, one of the oldest physicians of Savannah, died February 14, 1909. Dr. Johnstone was in his eightieth year and was a veteran of two yellow fever epidemics in Savannah as well as having served in the civil war.

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Dr. W. W. Bruce, of Kingsboro, died February 11, at the age of ninety-one years. The death of Dr. Bruce removes one of the most prominent figures of the medical profession of West Georgia.

Dr. W. B. Armstrong, one of Atlanta's most prominent physicians, died at his home on Washington street, on February 8, having been sick only a few days.

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At a recent meeting at the Grady Hospital, the following were elected as members of the Medical staff from the Atlanta School of Medicine, from A. C. P. & S.

Medicine.—Dr. R. F. Dorsey, Dr. J. C. Olmsted, Dr. L. B. Clark and Dr. C. W. Strickler.

Surgeons.—Dr. L. C. Ficher, Dr. Goldsmith, Dr. F. K. Bolland.

Obstets. and Gyn.—Dr. Geo. H. Noble and Dr. Jno. F. Ernest.

Ear, eyes, nose and throat.—Dr. R. B. Ridley, Jr., and Dr. F. C. Calhoun.

From the city at large:

Medicine.—Dr. C. G. Giddings and Dr. L. P. Stevens.

Surgery.—Dr. Walton P. Jones and Dr. J. N. Ellis.

Obstets. and Gyn.—Dr. W. A. Crowe.

Ear, eye, nose and throat.—Dr. A. W. Stirling.

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Announcement is made in the last issue of the Chicago Clinic and Pure Water Journal that the able editor, Dr. Thomas G. Atkinson, of the Medical Standard will assume the general editorial supervision of the former journal.

The excellent work, and charming poems written by the former editor will be greatly missed by the readers of the Clinic.

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At a regular monthly meeting of the medical board of the Grady hospital the following officers for the ensuing year were elected: Dr. Rufus T. Dorsey, president; Dr. W. S. Goldsmith, ice president, and Dr. C. W. Strickler, secretary.

A committee was appointed to draft suitable resolutions on the death of Dr. W. B. Armstrong, and read them at the next meeting of the board.

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A Conundrum.—Into a general store of a town in Arkansas there recently came a darky complaining that a ham which he had purchased there was not good.

"The ham is all right, Zeph," insisted the storekeeper.

"No, it ain't, boss," insisted the negro. "Dat ham's shore bad."

"How can that be," continuer the storekeeper, "when it was cured only last week?"

The darky scratched his head reflectively, and finally suggested:

"Den mebbe it's had a relapse."—*Cleveland Leader*.

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The Point.—At a dinner during the recent Episcopal convention at Richmond a young lady sitting near the bishop of London said to him, "Bishop, I wish you would set my mind at rest as to the similarity or dissimilarity between your country and ours on one point. Does the butterfly because the tomato can?" The bishop laughed heartily at this vivacious sally. Not so a young Englishman of his party, who, after dinner, sought his host. "I want to know, you know," said he, "about that joke of Miss B.'s. She asked if the butter flew because the tomatoes could. Pray tell me what the point is."—*Christian Register*.

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#### REGULAR MEETING FULTON COUNTY MEDICAL SOCIETY, NOVEMBER 19, 1908—DR. STIRLING IN CHAIR.

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REPORTED BY DR. R. R. DALY.

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Dr. Theodore Toepel read his paper upon "Active Exercise in the Treatment of Locomotor Ataxia," which was published in the December issue of the *Journal-Record of Medicine*.

It was discussed by Dr. Daly, who commended the detail and precision of the exercises described.

Dr. Thrash called attention to the distinct gain in the patient's comfort through the means described and noted the psychologic effect following the knowledge the patient gained of his capabilities.

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#### MEETING OF FULTON COUNTY MEDICAL SOCIETY, DECEMBER 3, 1908—DR. STIRLING IN CHAIR.

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Dr. J. Cheston King read a paper upon "Paralysis Following Acute Disease or Due to a Specific Virus."

It was discussed by Dr. Duncan who said that after Diphtheria he had often seen regurgitation of solid as well as liquid foods. He differed from the writer as to the antecedents of tabies always being syphilitic. He knows of cases wherein no syphilis could be discovered.

Dr. Armstrong also said he knew of cases of tabes in which there was no syphilitic taint. It appeared in three generations under his observation, viz: grand-father, son and grand-daughter, and none of these had any marks or history of syphilis.

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#### REGULAR MEETING FULTON COUNTY MEDICAL SOCIETY, DECEMBER 17, 1908.

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This was the annual meeting of the society and the President's address was read. The members received it with great satisfaction and approved emphatically many of the suggestions it contained.

At the election of officers, the following were elected: President, C. W. Strickler; vice-president, J. Ross Simpson; secretary, E. G. Ballenger; treasurer, A. H. Lindorme; Censor, M. Hoke.

Drs. Roy and Lokey were appointed to arrange for the annual banquet.

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#### REGULAR MEETING FULTON COUNTY MEDICAL SOCIETY, JANUARY 7, 1909, HELD AT THE ARAGON HOTEL—DR. STRICKLER IN CHAIR.

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The officers elected at the previous meeting were installed and Dr. Strickler took the chair.

Dr. Stirling presented the society with a fine new gavel, which was accepted by Dr. Strickler.

Dr. Strickler then gave his inaugural address which is published elsewhere in the Journal.

Dr. Olmsted discussed the address: See special article.

Dr. Claude Smith urged that the vital statistics be better attended to by physicians. The birth rate is slowly increasing,

but this may be due to better reporting. He wants the reports made so carefully that they can be depended upon.

Tuberculosis is not reported as it should be because people are not convinced that it is a communicable disease, and they fear isolation as a result of reporting. The percentage among negroes is decreasing.

Pneumonia is increasing among negroes from 32 per cent. to 08 per cent.

Typhoid fever seems more fatal recently though less in quantity.

Dr. Cartlege said in regard to quacks, that he knew of a "specialist" who was examining and treating patients free but he had made arrangements with a druggist whereby cheap drugs were sold to the patients as strange, foreign medicines at enormously high prices and the quack got his money in that way.

Dr. Hoke urged co-operation among the members in supporting a library and told of a new plan to have a special room in the Carnegie Library for the Medical books.

Dr. Niles using the classic legend of Joshua with his hand upheld by his friends, as a text, showed how the members should support the President in all his recommendations.

After adjournment the members enjoyed a banquet in the hotel dining room after which there were numerous speeches.

Credit should be given Drs. Roy and Lokey for the excellent manner in which these arrangements were made.

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REGULAR MEETING FULTON COUNTY MEDICAL  
SOCIETY HELD IN CARNEGIE LIBRARY, JAN-  
UARY 21, 1909. DR. STRICKLER IN CHAIR.

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Dr. Niles read an excellent paper upon "Aesthetic Alimentation" that appears elsewhere in the Journal.

Dr. Olmsted said that none of us could fail to appreciate the prose, poetry and the splendid common sense of the article. He thoroughly agreed with the essayist upon the excellent effects of aesthetic surroundings and pleasing deliberation at meals. The happy, contented frame of mind was necessary to good digestion and good mental cultivation. He advised that the paper

be published in the public prints so as to reach the people most in need of just that sort of thing. He said that the old adage, "after dinner, sit awhile," was of the soundest hygiene. The national disease of dyspepsia was due to our hurrying at eating and hastening thence to work, either physically or mentally, without giving the stomach a chance to do its work.

In closing, Dr. Olmsted paid a tribute to Dr. Niles, saying he was proud that the strenuosity of the times had not done away with the use of the literary grace in the consideration of medical topics.

Dr. Amster said he had listened with pleasure to the essay and heartily commended the idea of proper serving of food. He had noticed many times the difference in the reception patients gave food trays in the hospitals depending upon the aesthetic condition of the meals. It is a distinct advantage to have everything nice and dainty. He wanted to emphasize in addition the necessity for proper selection of food and the manner in which it should be cooked. He believes that doctors should give specific directions along this line, rather than leave the matter to the cook or family. Doctors in Europe are given instructions in cooking so as to enable them to direct their patients' dietary more precisely.

Dr. Roy said that aesthetics should be considered at the hospitals more than they were. He thought, perhaps, Dr. Amster had not noted that Dr. Niles had already taken proper selection and preparation so far as cooking went, for granted.

Dr. Niles in closing agreed with Dr. Amster as to selection and re-read a sentence in his paper showing that idea.

Dr. Stirling read his paper upon "Retro-bulbar Optic Neuritis."

Dr. Roy in discussion said that this condition is a confusing one because the apparently normal disc in the early stage seems to belie the serious condition. Also later on the white disc sometimes indicates complete blindness when the patient sees well. The classic symptoms of pain on motion of the eye, dimness of vision, central scotomata and prevented color sense ought to make the diagnosis clear and these things should be kept in mind as a warning of possibly ensuing multiple sclerosis even if the first attack were recovered from.

The prognosis of this disease is good in his estimation if

treated properly during the first eight days. Later it is bad. The remedies he has found most satisfactory are iodide of potassium, mercury and pilocarpine.

Dr. Stirling in closing, said he agreed with Dr. Roy as to multiple sclerosis, but not as to the eight day limitation period of successful treatment.

Dr. Westmoreland read an exhaustive paper upon "Morbid Reflex Neurosis."

Dr. Davis said he was most impressed by neuroses depending upon deformities of the female genitalia. He told of two girls, 9 and 6 years of age, relieved of neuroses by clearing adhesions at the clitorides. Another child was always pressing her hand there because of the irritation and was about to become a masturbator when operation removed the cause.

Four of five female masturbators were cured of the habit by removal of the adhesions. He related the case of a woman who couldn't walk because of spasm in the tendon of achilles. It was relieved by the prepuccial operation. As to fessure in ano, he thought that the speculum gives more force than the thumb and fingers and when judiciously used, makes the better method.

Dr. Goldsmith said that is true, there is more force in the speculum; but one loses and destroys the best guide he has when he keeps his fingers away from the muscle. He thinks Westmoreland's method gives the safe stretching to every fiber of the muscle.

He told of a case of pain in left testicle and left kidney due to organic urethral stricture that was relieved by proper treatment of stricture. He insisted that urethras should be examined with bulbaros sounds instead of the straight shank if one wanted to know anything about the size of the band. He agreed that all four operations should be done if there were the slightest indication for them: Circumcision, slitting the meatus, removing varicocele and stretching canal sphincter.

Dr. Fowler said that the pinhole meatus causes incontinence as well as retarded urination. Oxalate and uric crystals frequently were caused by meatal irritation. He told of a case of a man whose long prepuce reacted upon his nerves so that he frequently could not control feces when urinating. He recovered after circumcision.



Chronic prostatitis caused itching anus and severe mental depression in one of his cases.

Ureters were catheterized four hours in one case and caused both testicles to be drawn into their rings.

Dr. Ballenger said that diseases and irritations of the prostate gland cause a wide range of symptoms in which mental depression is prominent. He believes in thorough treatment of these surgically and then adding the psychic elements so as to encourage the patient in recovery. He gave a word of warning as to over-zealous meatotomy. He knows of patient cut so widely open as to have to sit down when he urinates in order to keep the stream in the proper vessel.

Sexual neurasthenics are to be helped by relief in these parts and the proper advice following.

Dr. Olmsted said that he recalled the days when there was the beginning of much cutting of the meatus and several were too wide. The Otis sound is the only safe guide as to the condition in his estimation and the incisions should be deep enough to remove the ring when it extended beyond the mucous surface. Spasmodic strictures have been operated upon through the perinaeum before the proper examining methods were evolved. He told of a case of a small boy seemingly paralyzed and wearing some sort of apparatus upon his leg, who was cured of all trouble by circumcision and meatotomy.

Dr. Lokey told of boys suffering with dimness of vision, but having no refractive trouble, cured by circumcision.

Dr. Visanska told of some gastro-enteric difficulties in children cured by circumcision when direct remedies had failed.

Dr. Westmoreland said in closing that if membrane at meatus is thick it must be cut as deeply as it goes and the thicker it is the more must be allowed for subsequent cicatricial contraction. From 1 to 3 millimeters are needed. Moreover, he always re-examines after recovery and if there isn't enough room, he cuts again. He told of a case of renal calculus caught in meatus. Meatus was enlarged and calculi did not recur. This may have been due to free urination and no retention of amorphous urates.

Withdrawing before sexual connection is complete and the use of condoms cause congestion of parts for which there is no cure except cessation of the habit.



Adhesions at prepuce should be broken up because they sometimes cause carcinonia.

Aphonia and spasm of oesophagus have been relieved by removal of prepuce.

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## BOOK REVIEWS

**A SYSTEM OF SYPHILIS.** In six volumes, edited by D'Arcy Power, M. B. Oxon., F. R. C. S. and J. Keogh Murphy, M. D., M. C. Cantab, F. R. C. S., with an introduction by Jonathan Hutchinson, F. R. S. Volume I, Introduction, History, Microbiology, General Pathology; Early Manifestations in Male and Female, and Congenital Syphilis. Oxford University Press, New York and London. Price for set, \$81.00, single volumes, \$13.50.

This monumental work in six volumes devoted to syphilis, and dedicated to Schaudinn, Fournier, Hoffmann and Hutchinson, is an example of the magnitude of medicine today and of the thorough manner in which medical literature covers the various subjects.

The time for the appearance of this work is particularly opportune, as the discovery of the *spirochaeta pallida* has wrought such remarkable changes in many of our views of the pathology, to have a work comprehensive in all its details when viewed from the new standpoint makes it exceedingly important to possess such a work as the one we now have under review.

The readable introduction by Hutchinson touches briefly upon the important and mooted points concerning syphilis, and suggests lines for much profitable thought and investigation. Bloch in discussing the origin of syphilis presents much evidence in favor of the view that this disease was carried to Europe by the crew of Christopher Columbus.

The microbiology of syphilis is treated upon by Elie Metchnikoff, who has taken such an active part in establishing the *spirochaeta pallida* as the true cause of syphilis, by the inoculation of anthropoid apes and chimpanzees, which thus opened a wide field for useful experimentation; photomicrographs of the *spirochaeta pallida* stained in smears in tissue and shown by reflected light are presented in excellent cuts.

The general pathology of syphilis written by F. W. Andrews may truly be said to be a masterpiece of medical literature; his clearness of diction and fascinating style make one loath to lay aside the work. Space forbids the mention that should also be given to the chapters by Lampkin, Shillitoe and Still.

The splendid colored plates deserve especial commendation as also does the translation of certain chapters and binding. So interested has the reviewer been in reading this volume that it will be with impatience that he awaits the appearance of subsequent volumes.

E. G. BALLENGER, M. D.

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**DISEASES OF THE SKIN AND THE ERUPTIVE FEVERS.** By Jay Frank Schamberg, A. B., M. D., Prof. of Dermatology and Infections Eruptive Diseases in the Philadelphia Polyclinic and College for Graduates in Medicine, etc. Fully illustrated. Published by W. R. Saunders Co., Philadelphia. Price, \$3.00 net.

There is no branch of medicine which presents so many puzzling features to the general practitioner as diseases of the skin. We do not believe there is a recent book on dermatology which affords the physician, however, a more excellent and concise discussion of the diagnosis and treatment of these diseases than does Schomberg's latest work. While the section on Eruptive Fevers has received especial attention, the cutaneous manifestations of all diseases of the skin are considered; the work is really a concise one on dermatology including the latest advances in actinotherapy, roentgentherapy and studies in radium.

The book is attractively and substantially bound and contains 204 illustrations, which add much interest to the work. Considered as a medium size book on Diseases of the Skin the reviewer thinks the book deserves the highest commendation.

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**THE CHANGING VALUES OF ENGLISH SPEECH.** By Ralcy Husted Bell, published by Hinds, Noble and Eldredge, New York. Price, \$1.25, 304 pages.

Dr. Bell has a most fascinating style of expressing himself, both in prose and in verse and when he combines the poetic and

artistic, as he has done in the above work, we think it well worth while for any one caring in the least for good English to read and reread this book, both for its subject matter and for its quality as a piece of beautiful literature. He is quite hostile in his criticism of the reformer of our spelling; he says: "the trouble with these expounders is, that their learning confuses rather than clarifies their understanding. Over specialized endeavor often distorts the perspective." He thinks the changes are natural and evolutionary in character and that they are not to be done by the wholesale.

The writer does not remember ever to have read more beautiful poetic prose than much of the writing of Dr. Bell, who formerly was a practitioner even as we.

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DISEASES OF THE SKIN. By A. H. Ohmann-Dumesnil, A. M., M. E., M. D., Ph. D., etc. Formerly professor of Dermatology and Syphilology in the St. Louis College for Medical Practitioners, the St. Louis College of Physicians and Surgeons, etc. Third edition thoroughly revised and enlarged, 140 illustrations. C. V. Mosby, Medical Book and Publishing Co., St. Louis, Mo.

The author states in his preface that his intention has been to make of this book a practical guide to the easy recognition of the skin diseases, as well as of their successful treatment. There are ten chapters and an appendix containing two on diet in skin diseases and on food eruptions. Dr. Ohmann-Dumesnil has succeeded well in carrying out his intention and has presented in a clear, concise manner just the information most desired by students and general practitioners. Numerous prescriptions are given in such a manner as to make it exceedingly easy to apply the treatment recommended. All of the illustrations are good and some of them of unusual interest. We can commend it as a practical book for practical doctors.

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SURGICAL MEMORIES, by James G. Mumford, M. D., Instructor in Surgery, Harvard Medical School; Visiting Surgeon to the Massachusetts General Hospital; Fellow of the American Medical Association. Illustrated, \$2.50, net. Moffat, York & Co., New York.

In this volume Dr. Mumford has collected many of his in-

teresting papers and addresses, and has added some material hitherto unpublished. The first essay is a narrative sketch of the history of surgery, and embraces accounts of the great heroes of that art; Hippocrates, Galen, Vesalius, Pare, Haller, John Hunter and Lister receive much attention in a philosophical and scholarly manner. Then follows a paper summing up ancient surgical accomplishments; succeeded by biographical essays on Cooper, Brodie, J. C. Warren and Bigelow. The remaining papers are short essays; accounts of special American achievements in medicine; a critical and historical essay on aneurysm; addresses to nurses, and short papers on ethics and on medical education. Altogether Dr. Mumford has produced a book of much interest to those who care to know something of the history of surgery, and who of us does not?

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**PATHOGENIC MICRO-ORGANISMS INCLUDING BACTERIA AND PROTOZOA.** A practical manual for students, physicians and health officers, by William H. Park, M. D., Prof. of Bacteriology and Hygiene, University and Bellevue Hospital Medical College, New York, etc. Assisted by Anna W. Williams, M. D., Assistant Director of the New York Research Laboratory. Third edition, enlarged and thoroughly revised, with 176 engravings and 5 full page plates. Lea & Febiger, Philadelphia.

The above work is characterized by clearness and practicality; combined with these one finds that the work is thoroughly up-to-date as is shown by the chapters on opsonins and the spirochaetae. It seems eminently suitable to the student and practitioner.

Part I is devoted to the principles of bacteriology, and gives concisely the well known facts, as well as discusses much that is new in this subject, viz: The antagonism between our bodies and micro-organisms; the nature of the protective defences of the body—Ehrlich's "side chain" and other theories; agglutination, etc.

Part II includes bacteria pathogenic to man, individually considered; bacteriology of milk and water.

Part III is given to a modern discussion of Protozoa. Few branches of medicine have made more rapid progress in recent

times than has this subject; these advances are clearly reflected and concisely stated in this part of the work. The book concludes with a glossary defining the many new words that have arisen from the development of bacteriology and mininity; the fact that many of these words are not given except in the most recently published dictionaries makes it a distinctly useful feature.

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A TEXT-BOOK OF HUMAN PHYSIOLOGY, theoretical and practical, by George V. N. Dearborn, A. M., (Harv.), Ph. D., M. D., Prof. of Physiology in the Medical and Dental Schools of Tuft's College, Boston, etc. Illustrated with 300 engravings and 9 plates. Lea & Febiger, Philadelphia.

This book was written primarily for medical and dental practitioners and students and will undoubtedly be warmly welcomed by them, especially the students who have recommended to them by their professors the most enormous, verbose, and complete books that can be obtained; instead of aiding him these voluminous works only bewilder the poor overworked student and often so discourage him that he will not wade through all the detail of experimentation and theories for the few facts which would enable him to pass reasonable examinations and to assist him in his subsequent professional work. If there is one subject needing reforming in our medical colleges it is this question of selecting suitable text-books; they should be suggested with the student's meager knowledge and limited time in view rather than as a pedantic display of one's familiarity with and commendation of the voluminous works which, while most excellent, are not suitable to the student.

This work apparently presents the essential details and the principles of physiology in an attractive form and while not as simplified as might be, is a distinct improvement over some of the works now being recommended for students. The many, and excellent illustrations assist greatly in presenting clearly the subject matter. We heartily commend this book and would like to see a set of books, for students, more like it.

The author acknowledges his great indebtedness to some of his colleagues and students in the preparation of the text and illustrations, but rather stingily refrains from mentioning their names.

There is less likelihood of injuring the deeper vessels in excising tonsils if the instrument is pressed in deeply to engage the organ rather than exerting pressure from the outside.—*American Journal of Surgery*.

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An hypertrophied lingual tonsil sometimes causes much discomfort, giving a heavy, sore feeling to the base of the tongue. It may be necessary to remove it.—*American Journal of Surgery*.

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Hard tonsils preponderating in connective tissue, are better removed by the cold snare than by a sharp instrument. The snare closes the blood nerves; the tonsillitome opens them.—*American Journal of Surgery*.

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The differentiation between a specific and tuberculous ulcer of the fauces is sometimes very difficult. As a rule the specific ulcer is shallow, grayish, with a regular margin, not very tender and does not cause dysphagia; on the other hand, a tuberculous ulcer is deeper, more sloughy, irregular in outline, has an outer inflammatory zone, is exquisitely tender and causes great pain on swallowing; laryngeal examination may reveal a tuberculous condition of the cords.—*American Journal of Surgery*.

Suppurating arthritides do not always require exposure of the joint or even large incisions, irrigation and drainage. Such treatment invites mixed infection and ankylosis. If the pus be very thin—even though of streptococcic origin—thorough aspiration (which may need to be repeated) and immobilization may effect a rapid cure with perfect function. Purulent arthritis and peri arthritis as it occurs in small children as a complication of one of the exanthemata (often in connection with trauma) is often quite amenable to conservative, and even ambulant treatment; aspiration, or irrigation and drainage, and immobilization. Judgment is needed, of course, to determine what cases are amenable to this conservative surgery, and what point in the treatment it must be abandoned in favor of more extensive intervention.—*American Journal of Surgery*.

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### **MEDICAL ITEMS**

#### **PHYSIOLOGICAL CELL NUTRIFICATION.**

In this impelling period of intense activities the vital forces are often called upon to appropriate their substance to the limit of structural stamina. The consuming folly of unbridled ambition now prevailing depletes the organism, impoverishing the cellular structures of their protoplasmic content and establishing a condition of metabolic retrogression and a faulty and embarrasses neurogenesis.

To meet these conditions the most pressing therapeutic needs is for efficient reconstructants to the neuroblastic process.

That neurasthenic and anemic manifestations and propensities are increasing to a disquieting extent is evident, and to provide physiological and reconstructive agents to encourage the process of cellular co-ordination and progression is the considerable labor in which the biological and pharmaceutical chemist is now most engaged.

That basic nutritional therapy directed to the physiological processes of cell genesis is of paramount importance is shown by



the growing interest of the physiologist and the physician in this comprehensive avenue of applied therapeutics.

It has been shown that iron, manganese and phosphorus constitute in the human economy the salient material elements most essential to tissue elaboration and prpopgrpression.

Iron, if in a form suitable for sell absorption, enriches the hemaglobin content of the blood and contributively effects, with the manganese, a healthy and normal arterialization. According to Loomis, Bunge and others, maganese exerts on oxigenating influence in excess of iron; the two elements together, however, excite a vigorous stimulation of the sluggish arterial currents, encouraging a return to progressive and sustained cell genesis.

That organic iron and manganese have, in therapeutics, established their ascendenc over allied inorganic substances is not remarkable when it is remembered that each of these elements is found to exist in the economy in the form of an albuminate.

Notwithstanding these facts there has been some disappointment in the use of physilogical iron and manganese. This partial failure may be traced to a very logical circumstance—a conclusion proved beyond the postulate.

Clearly, in the light of biological research, iron and manganese, while important and useful as blood oxigenators and enrichers, do not fully represent the correlation of reciprocal elements esesntial to a vigorous and sustained hematosiis; nor are they sufficient in themselves to establish progressive tissue elaboration; physiological phosphorus is required to round out the therapy of these valuable hematinics.

It was to meet the growing demand for a true physiological phosphoid nutrient and tissue builder that Phospho-Ferrum was offered the clinical body.

This preparation represents organic iron, organic manganese, phypysiological phosphorus—the lime salt of glycerophosphoric acid—and beef proteids, compounded into an agreeable liquid galenical of a deep vinous color and a grateful, aromatic odor and taste.

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## PNEUMONIA.\*

BY JAMES B. BAIRD, M. D., ATLANTA.

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Acute lobar pneumonia is an acute infectious disease. An infectious disease is one caused by the entrance and propagation in the living body of pathogenic micro-organisms. In this particular disease, the infectious agent is the pneumococcus, known also as the diplococcus of Fraenkel and as the micrococcus or bacillus lanceolatus.

Frequently associated with the pneumococcus, are the streptococcus, the staphylococcus and the bacillus of influenza, of diphtheria and of typhoid fever. The pneumococcus is often found in

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\*Read before the Fulton County Medical Society.

connection with lobular, catarrhal or broncho-pneumonia—though this type of the disease is usually due to a mixed infection, in which the bacillus of Friedlander holds a more or less important place.

Some bacteria produce more than one toxic agent, but the pneumococcus appears to be responsible for only one toxin, and the resulting toxæmia plays an important role in the clinical history of pneumonia.

It is confidently alleged by competent observers that the usual local expression of this infection—an exudative inflammation of the lung tissue—is not an essential part of the morbid process, but that a general pneumococcic sepsis may exist and run its course without the development of the ordinary local lesion in the lung. It is a well established fact that pneumonia is an essential fever, and that the inflammatory lesion is merely a local expression of a general condition.

Many years ago, that master medical mind—that great prophetic sage, the late Austin Flint, wrote:

“Acute lobar pneumonitis, in the nosological systems of the present as of the past time, is placed among the local diseases, and in regard to certain questions it has been regarded as the type of a purely inflammatory affection. This view of its pathological character is now held to be erroneous. The pulmonary affection is doubtless inflammatory; but it is the local manifestation or the anatomical characteristic of an infectious febrile disease, sustaining to the latter a relation analogous to that which the affection of the solitary and agminated intestinal follicles sustains to typhoid fever.” He continues: “If this doctrine be true, the proper place for the disease in the nosology is among the essential fevers. There are sufficient grounds for regarding the disease as an essential fever, and we may define it as a fever characterized anatomically by an abundant exudative deposit in the air vessicles of a single lobe or of two and sometimes three lobes of the lungs, with, in general, circumscribed bronchitis and dry pleurisy. It is a fever which rapidly reaches its maximum intensity, and has a short career the duration averaging about eleven days. It proves fatal chiefly in consequence of associated diseases, complications, or accidents, and, in the mode of dying asthenia usually predominates. It depends on a cause or on causes specific in character, the nature of which is not at present established.

It may be favorably modified, its duration abridged and the danger to life diminished by treatment addressed, not to the pulmonary affection, but to the fever."

Pneumonia is a frequent complication of other diseases, especially of typhoid fever, erysipelas, cerebro-spinal meningitis, dysentery and tuberculosis, and among the most common and the most important complications of pneumonia are meningitis, jaundice, acute arthritis and nephritis. It attacks all ages, but by preference young adults; men oftener than women; the vigorous and robust as well as the debilitated subject. It prevails in all countries; upon the mountain top and at the sea level. Its favorite season, in this section, is the early spring. One attack does not afford immunity from subsequent attacks, indeed, exactly the reverse is true. The susceptibility is increased after the first attack, and more than twenty distinct attacks in one individual are recorded.

Statistical data from many of the most populous cities of this country prove that it is now the most fatal of all infectious diseases, having within the last decade exchanged places with tuberculosis, which formerly stood at the head of mortality lists.

The period of incubation is short, very short, probably not more than a few hours. The invasion is abrupt. The initial chill, which usually marks the advent of an attack, followed by high fever, a short, frequent, dry cough, rapid respiration, redness of one or both cheeks and sharp pain in the region of the nipple on the affected side direct attention to the chest, and these symptoms alone afford strong presumptive evidence of the existence of this disease. Soon, the occurrence, in most cases, of the crepitant rale with tenacious, rusty sputum—which are pathognomonic—and, later, dullness or flatness on percussion, with bronchial respiration and bronchophony, establish the diagnosis.

In the majority of cases, the local morbid process commences in the lower lobe of the right lung. The lower lobe of the left lung comes next in order of frequency. Exceptionally, an upper lobe is primarily attacked. It is thought that unusual severity generally attends an attack beginning in an upper lobe. Independent involvement of the middle lobe of the right lung seldom occurs. When a second lobe is invaded it is not a mere extension of inflammation by contiguity, but it means the establishment of a new focus of infection. This advance may be indicated

by increase of fever, but the chill pertaining to the original invasion is not repeated. Bronchitis in the affected lobe or lobes is always present, so, also is circumscribed, dry pleuritis. Except, rarely, when the superficial portion of the lobe is not involved in the inflammatory process, which begins at one or at several distinct points and extends from lobule to lobule until, in most cases, the entire lobe is included. Occasionally, however, conclusive evidence of the precise nature of an attack, which is afforded by physical signs, is delayed for several days after the development of the general symptoms. This is true of the, so-called, central pneumonia in which the morbid changes begin in the deeper portion of the lobe and only gradually approach the circumference. The so-called creeping pneumonia may manifest the same peculiarity and indeed, an attack sometimes appears to begin as an ordinary influenza, the physical signs of pneumonia not being appreciable for a week or more. Abundant herpes labialis is a very common symptom. Leucocytosis, more or less marked, is present from the beginning to the termination of the fever. The chlorides in the urine are greatly diminished or are wanting during the same period. Active, even violent, delirium may suddenly develop, and the attendant should be warned of this possibility and be prepared for the emergency. Most cases end abruptly by crisis, from the third to the twelfth day. If the attack should be prolonged beyond the twelfth day it indicates a probability of ending by lysis.

The essential and the dangerous element in pneumonia—as pneumonic fever—seems to be a specific toxæmia, and as there are no available means of correcting this condition—if we are without effective antidotes or antitoxins, it is possible at least, by timely resort to well-known therapeutic agents to promote tolerance, within the body, of this elusive poison, and, in the existing state of knowledge, it is only in this direction that we may look for success. Therefore, in the treatment of pneumonia, we may gracefully accept the fact that there is no certain prophylactic, and no specific medication. But this assertion is not, by any means equivalent to an admission that judicious management is not conducive to favorable results, or that all treatment is useless. Some of the prominent symptoms should be met, and familiarity with the natural history of the disease furnishes unmistakable clinical indications. The cough and pain usually require anodyne remedies. Insomnia may call for hypnotics. Fever deserves special

attention, and the tendency toward asthenia affords ample ground for the employment of sustaining measures. Blood-letting, once thought so appropriate in this disease, is seldom indicated. Only very infrequently will distressing dyspnoea, associated with a full, bounding pulse, early in the attack, justify its use. The benefits formerly attributed to it may generally be secured by less objectionable means, and the loss of the precious fluid, indispensable to physical welfare, may thus be avoided.

It would be remarkable indeed—a veritable clinical anomaly—if sustained high temperature in this disease is, as has been alleged, not injurious but rather serviceable to the patient. Yet, strange as it may seem, this view has not only been advanced, but has been seriously defended, and to a limited extent has been accepted as true. If the temperature should remain at or about 103 F., it is, in my judgment, important to save the nervous system from the exhausting effect of this heat, and antipyretics should be employed for this purpose. Partial sponging with tepid water and the ice cap to the head are the means to be preferred, but if they fail, and, unhappily, they often do, drug antipyretics should not be withheld. The medical profession may have sins of omission as well as sins of commission justly laid at its door. Denying this relief, when it is clearly indicated, belongs to this category. I consider phenacetine, in suitable doses the best of this class. Properly employed, when not distinctly contra-indicated, by existing feebleness of the pulse, it is certainly harmless and positively beneficial. It does not act as a depressant when it subdues fever, allays distress and secures rest. If these palpable advantages follow its use, the effect contributes directly to support, and the drug would therefore seem to deserve credit for the conservation, not for the dissipation of strength and such, in fact, appears to be the case.

Thorough elimination deserves special attention. The presence of a potent poison in the blood is an important feature of an attack. It is assumed that the ordinary channels may be profitably employed for the removal of this toxin. Patients should be encouraged to drink water freely, and cathartics, as required, should be administered. Standing pre-eminent among all the drugs which are classed as eliminants—far above all others—is calomel. With its undoubted power to arouse the excretory functions, it holds an important place in the approved therapeutics of this disease.

Death comes to mankind either from failure of the circulation or of the respiration—from asthenia or from apnoea. It is rarely the case that respiratory failure determines the issue in pneumonia. The dreaded tendency is toward asthenia, and the recognition of this undisputed fact, furnishes the key to proper management. To be fore-warned is to be fore-armed, and with this knowledge, we are derelict if we defer the use of measures designed to avert this recognized tendency. A liberal, liquid diet should be provided and the early use of both tonics and stimulants—strychnine with whiskey or wine, in doses best tolerated—should always be advised. The latter to be omitted only in the event of an individual peculiarity adverse to their use. It is a grave mistake to wait for signs of failure before resorting to these measures. It is an unfortunate error of judgment to postpone acting until the evidence of exhaustion is apparent. We know, or ought to know that this danger is to be encountered, and it is our simple duty to forestall its development if we can.

In decided failure of the circulation as shown by increased frequency and diminished force of the pulse, digitalis may, with benefit, supplement other means. Its use should not be declined because of alleged inefficiency in febrile conditions. Progressive prostration may be met by increasing alcoholic stimulation regardless of the dose until the desired effect is obtained, remembering that in this disease, as in other infectious diseases, extra-ordinary tolerance of alcohol is sometimes manifested. Aromatic spirit of ammonia is a valuable adjunct on special occasions and strychnine, at this juncture, should be given hypodermatically rather than by the mouth. In approaching collapse, the effect of a solution of camphor in ether, hypodermatically, by its stimulating influence upon the nervous system, is sometimes truly remarkable.

Excepting sinapisms to the chest for pleuritic pain, I have long since discarded external applications. Blisters are only useful in the event of delayed resolution, when repeated small blisters over the affected part undoubtedly stimulate the tardy function of absorption. Padded and oil-silk jackets, poultices, plasters and the like are uncomfortable, inconvenient and of no value. This estimate applies alike to fomentations, to flaxseed meal and to a highly lauded—a so-called elegant compound of glycerine and white clay. By indorsement of this latest specific, an unsuspect-

ing and innocent profession may largely augment the dividends of the enterprising manufacturers, and we may rest assured that our confiding patients are not the real beneficiaries.

Fresh air, and a plenty of it, is indispensable, but ordinary ventilation of the apartment occupied by the patient is sufficient; any excess is unnecessary if not injurious.

If the so-called open air treatment—out-of-door sleeping—is ever, under any circumstances, or in the treatment of any disease, advantageous, the conditions regarded as favoring its adoption can scarcely be compared with the conditions which obtain in acute pneumonia. Even in those pathological states in which the leading advocates of this out-door life claim most, they do not advise that any patient shall be suddenly thrust out of doors. The best exponents of the plan—but not their untutored imitators—urge the importance of gradually accustoming the patient to untried exposure, which wise precaution is inapplicable of course, in any acute illness of short duration.

Extreme measures as a rule are not to be commended. Conservatism and moderation represent a principle in therapeutics which it is highly desirable to recognize and to regard. If enough is enough, then it must logically follow that too much is too much. The "golden mean" is a proverbial phrase which possesses practical significance. But alas, this new method, this extreme method, this irrational method, this open air method presents spectacular features calculated to attract attention, to make talk and to impress the laity. It measures fully up to the dimensions of a fad and meets the requirements of an amazing and ever increasing demand for novelty.

If we will only exercise mental qualities with which we are all endowed in some degree, we may, at times, discover that we can do better than to blindly follow mistaken enthusiasts who assume the prerogatives of leadership. Nevertheless, when sheep begin to jump, the whole flock will heedlessly go through the gap with utter disregard of consequences.

Veratrum viride, once much used, is a remedy of genuine worth. It should be employed with caution, and it requires close watching. Extravagant claims have been made, of late, in favor of carbonate of creosote. Given in five-grain doses gradually increased to fifteen grains every two hours from the very inception of



the attack, it is said to reduce the temperature, to quiet the circulation and to bring about a favorable and early termination.

No serum treatment, so far tried, has yielded satisfactory results. It is to be hoped and expected that the future will show material advances along this line.

Remedies designed to promote expectoration are not indicated. Only an inconsequential part of the exudate—sometimes none at all—is thus thrown off. In favorable cases, the deposit in the air cells is more or less promptly absorbed by the forces of nature, leaving the lung in tact. It may be removed in this way with great rapidity and without cough or expectoration.

As the sputum contains the specific organisms of the disease it is probable that due attention has not heretofore been paid to its complete disinfection.

The inhalation of oxygen gas and the hypodermic use of atropine appear to be of service in certain stages of the small proportion of cases characterized by the occurrence of cyanosis or by evident respiratory insufficiency.

Relapses rarely occur, and while pneumonia does not tend to eventuate in other diseases, it is a mistake to allow the convalescent to leave the bed or to resume the usual diet too soon.

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### BLOOD IN THE URINE—SOME CASES.\*

(Continued).

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BY ALFRED L. FOWLER, M. D., ATLANTA, GA.

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PROFESSOR OF GENITO-URINARY SURGERY AND VENEREAL DISEASES  
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ETC.

pi and papillomata if they be present. If these are the cause of the hemorrhage they may be removed with the currette or the galvano-cautery.

3.—The next step in exploration of the bladder. With a velvet-eyed, soft rubber catheter we obtain urine directly from

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\*Read before the Fulton County Society of Medicine, January 7, 1909.

the bladder which should be kept and examined microscopically. The bladder is then irrigated with a 1 to 4,000 oxycyanat of mercury solution, followed by an injection of a dram of 4 per cent. cocaine solution with an Ultzman syringe into the prostatic and membranous urethra. General anesthesia has its disadvantages and is seldom necessary. After waiting about three minutes we may introduce the cystoscope; and it is advisable to employ both the prismatic and the direct view instruments. The former is more comfortable to the patient and, besides giving a better view of the ureters and trigonal tissue, prostatic hypertrophy and bleeding can often be seen. In order to see the prostate and anterior wall of the bladder, it is sometimes necessary to employ the retrograde cystoscope.

4.—Cystoscopy. For catheterizing the ureters and obtaining a better view of the fundus, I prefer, and generally employ Cabots direct view double-barrelled irrigating cystoscope.

Bladder dilatation by water excels by far the method of air dilatation; and in reason, because in the former we have a cool medium; moreover, an antiseptic medium; and then, too, the bladder is accustomed naturally, to containing a fluid, while air, now and then, acts upon it like a foreign body. Notwithstanding the disadvantages of air dilatation it serves our purpose when making local applications to a diseased area, if it be localized. When it is dilated by a clear, antiseptic fluid (e. g., oxycyanat of mercury 1 to 4,000 or 5,000) its folds are smoothed out and villous tumors, if present, may be easily detected floating free in the liquid medium. Also, if jets of blood or pus are issued from the ureters, if villous or papillomatous processes are bleeding, or if the prostate is causing the hemorrhage, or a vesical calculus, or ulcers be present, the cystoscope will bring them clearly into view.

Failure to observe a stone occurs in difficult cases where the calculus is embedded in a sacculum. Likewise, failure to locate the ureters occurs when they lie between folds of mucous membrane or are covered over by trabeculae. But such cases are the exception and generally it can be determined with certainty which kidney is affected and also the functioning power of each kidney. This functioning power may be determined by injecting methylin blue or phloridzin subcutaneously and noting the time that the urine becomes discolored, collecting it separately with

*ureteral* catheters. Albarran produces polyuria, experimentally, with a diuretic mineral water and collects the urine every half hour. The amount, its molecular concentration and amount of urea and chlorides are determined in percentages. His findings have been that in normal kidneys, the molecular concentration and the percentage of urea and chlorides diminish in the same proportion as the amount of urine increases. In diseased kidneys he usually found that the amounts of urea and chlorides diminished in disproportion to the increase in the amount of fluid excreted. *Cryoscopy* is of much value in this connection.

Cystoscopy has a distinct place, apart from its service as a means of diagnosis. It enables us, guided by the eye, to remove favorably located tumors with the snare, also to crush stones when not too large, with the cystoscopic lithotrite, and further to lavage the pelvis of the kidney in pyelitis and subsequently cure it.

Henry Meyer, of San Francisco, has recently reported some brilliant intra-vesical operations without the knife and Lewis Wine Bremerman, of Chicago, has lately been doing excellent work with the cystoscopic lithotrite, as devised by Walker, of Baltimore. In many cases cystoscopy reveals the kind of tumor we have to deal with as well as the location of the growth.

Contra-indications: Any acute inflammation of the bladder contra-indicates cystoscopy; and in such conditions it is not only harmful, but difficult. This is likewise true of the urethra and urethroscopy. In tuberculosis of the bladder it seems to aggravate the condition even more than other measures; and much harm can be done by unskillful cystoscopy in cases of villous tumors, particularly.

#### TREATMENT.

The proper treatment of hematuria involves not only the removal of the cause, when it can be determined, but also the associated conditions that not infrequently go hand-in-hand with it.

In inflammation of the bladder and kidneys, hot sitz baths and hot fomentations, together with saline cathartics, urinary antiseptics and diuretics are indicated. The diet (the diet should consist chiefly of bread and milk. The latter, while not alkaline primarily, shortly becomes so in reaction. Asparagus, tomatoes,

strawberries, etc., on account of the oxalic acid and a more complex substance called mercapton, which they contain, should be carefully avoided, as they act as irritants to the uro-genital membrane) should be as largely non-nitrogenous as possible, with as much absolute rest as can be obtained.

If the cause is attributed to the prostate, hot sitz baths, and the psychophore per rectum, as hot as the patient can comfortably stand it, are palliative measures not to be overlooked; also laxatives for the relief of venous obstruction, and removal of urethral constrictures either by operation or dilation, according to the cause and location.

In acute inflammatory conditions no attempt should be made, as a rule, to check the hemorrhage. Oil of turpentine, ergot, gallic acid, and other astringents, when administered by the mouth are of no value in *vesical* hemorrhage. In persistent hemorrhage of the anterior urethra lasting for three days, I once used locally a 15 per cent. Monsels solution very effectively. In slight vesical hemorrhage my experience has taught that aluminum sulphate, 2 to 10 per cent., and silver nitrate, from 1 to 1,000-500, used as hot irrigations (115-120 degrees F.) are the most reliable. Solutions of suprarenal extract frequently not only fail to do good, but they are irritating and occasionally start up a "sledge-hammer" pulse which, of itself, may bring about a condition equal to, or exceeding in gravity, the vesical hemorrhage. I have observed this particularly in bladders that have lost their tone.

Dr. Paul Sauvan, of Montpellier, France, is an earnest advocate of antipyrine in all forms of diffuse bleeding. He states that the vaso-constrictive action of this drug is not followed by paralytic dilatation, and recommends a 5 to 10 per cent. solution. Clinically, he finds that more than 150 grains have to be absorbed to produce toxic accidents. Administered internally antipyrine has no hemostatic action.

Vesical hemorrhage, the result of stone, is easily handled and preferably by suprapubic cystotomy. Villous or papillomatous tumors when located favorably may be removed by the snare. These tumors, now and then, give rise to desperate hemorrhage and such a condition calls loudly for suprapubic cystotomy. Nothing is gained in these cases by delay. The bladder should be opened, the tumor snipped off, and the actual cautery applied to the

bleeding point, if necessary. A 5 candle power incandescent light with which to illuminate the bladder facilitates the operation. The bladder wall stands the actual cautery very well, a fact that is also well attested in Botini's operation for hypertrophied prostate.

Malignant growths occasioning vesical hemorrhage of the bladder demand a suprapubic cystotomy. The tumor should be excised so as to include a portion of the healthy bladder wall. If this principle is not adhered to we are practically inviting its return.

Tuberculosis of the bladder and tubercular ulcers giving rise to vesical hemorrhage, can only be controlled by removing the cause.

If of the descending type nephrectomy will not only stay the process, but will be followed by a complete cure, once the primary tuberculous focus is removed. Irrigations of bichloride of mercury, beginning with a 1 to 10,000 or 1 to 5,000 solution about twice a week and gradually increasing to 1 to 1,000 and 1 to 500, probably gives the best results, locally. In cases of long standing the bladder is usually contracted and irrigations are not well tolerated.

I have seen a 20 or 30 per cent. solution of argyrol when injected into the bladder act almost like magic in allaying the pain and tenesmus in these cases, but have never observed any permanent results following its use. The usual medical (dietetic and hygienic) remedies may be tried; occasionally they seem to exert a favorable influence.

Tumors of the kidney and its pelvis, if they are the underlying cause of the hemorrhage, should be handled in the most radical surgical manner. Treatment consists in complete extirpation of the offending kidney, with as much ureter as possible, because these tumors frequently invade the ureters. Surgical interference depends entirely upon the diagnosis of disease in one gland only. By reason of our modern instrumentation and technique this can very readily be ascertained.

For stone in the kidney either nephrolithotomy or nephrotomy, dependent upon suppuration being present, is the operation.

Before reporting a few cases of hematuria, I desire to impress upon you these points:

1. The danger of acting too quickly before studying the case carefully.
2. The great danger in delaying in desperate hemorrhage.
3. The danger of aggravating the hemorrhage by clumsy instrumentation, such as cystoscopy, even when practiced by the experienced.
4. The preparatory treatment of the patient prior to instrumentation, particularly cystoscopy.
5. The value of local anesthesia in suprapubic cystotomy, particularly when the patient's condition contra-indicates general anesthesia.
6. The occasional occurrence of hematuria the result of acutely inflamed hemorrhoids.

## CASES.

1. Hemophilia. Mr. R. L. D., age 28, nativity, Louisiana, occupation, teamster. Patient asserted that he had gonorrhoea seven years ago. Diagnosis: Organic urethral stricture at peno-scrotal junction, and varicocele. Patient applied March 17, 1906, to seek relief for his stricture, he being unaware of his varicocele. Examination disclosed a dense, fibrous, inelastic stricture at the peno-scrotal junction. Internal urethrotomy was advised, to which the patient consented. After cutting this stricture a persistent urethral hemorrhage followed, which continued three days and nights. My suspicions were shortly aroused and, upon questioning him, I learned, that hemophilia existed in his family; and that on a former occasion he nearly bled to death as a result of an accidental fall, when he cut his lips with his teeth. Hot compresses, the usual styptics, and adrenalin gave no relief. On the third night the loss of blood continued unabated and the patient's vitality had begun to wane and little hope was entertained for his recovery, it being estimated that he had passed a pint of blood within the last three hours. Everything else having been tried, a 15 per cent. Monsel's solution was injected with an Ultzman's syringe into the region of the stricture; the hemorrhage ceased immediately and a long bloodclot about the size and shape of a pencil was expelled a few hours later, the patient making an uneventful recovery.

2. Hemorrhoids. Mr. W. C., age 32; nativity, North Carolina; occupation, soldier. Patient presented himself because he

said he was passing blood in his urine; had noticed it for ten days past, but never before. Urethral examination; negative. No venereal history. Rectal examination; showed acutely inflamed hemorrhoids. The prostate was found to be distinctly enlarged, soft and tender. Several specimens of urine obtained at various times showing a varying amount of hemorrhage, and occasionally clots. Centrifugalized urine revealed red blood cells, caudate cells and a few calcium oxalate crystals. Microscopic examination otherwise negative. The first and second glass tests were always clear. No symptoms of cystitis. Patient was sent to hospital and put to bed until acute inflammation of hemorrhoids had subsided. Meanwhile, the bladder was irrigated with potassium permanganate, boric acid, and silver nitrate solution. Urinary antiseptics and saline cathartics were administered with no appreciable effect. On September 18, 1906, assisted by Dr. A. P. Flowers, I operated on this patient for hemorrhoids. A good recovery. Two days afterwards the hematuria disappeared; and two weeks after this, examination of prostate showed that it had diminished in size and that its tenderness had disappeared. At last account, six months ago, there had been no return of hematuria. This case illustrates very clearly that hemorrhoids are, though rarely, a causative factor in vesical hemorrhage. When we consider the intimate association of the hemorrhoidal and prostatic plexuses in their relation to the neck of the bladder, the prostate and the anus, the case is not so surprising after all.

3. Villous Papilloma. Mr. J. M., age 41; nativity, New York; occupation, electrician. Patient appeared January 3, 1907, for relief of urinary hemorrhage. First glass test, clear; second and third glass tests showed a moderate amount of hemorrhage. Patient himself called my attention to what he called "a few small particles of fatty substances" mixed with the blood and urine. No cystitis present; and patient appeared to suffer more mentally than physically. Centrifugalized urine showed an abundance of red blood cells together with squamous epithelium and a few uric acid crystals. A diagnosis of villous tumor was made. Patient was put to bed; milk and bread diet ordered, together with cystogen as an urinary antiseptic. He was irrigated twice weekly with a 2 per cent. solution of aluminum sulphate, which was gradually increased in strength to 15 per cent. solution. Af-

ter the third week both the hemorrhage and villous particles began to disappear and by the fourth week there were no further evidences of either. Eight months after there had been no return and cystoscopy showed a practically normal bladder with no tumor present.

4. Passive Congestion of Kidney. Mr. B. F. H., age, 26; nativity, Georgia; occupation, painter. Early in March patient consulted me because he said he was urinating blood. He admitted having had syphilis four years previously. Physical examination showed a hypertrophied heart with a distinct mitral and aortic regurgitation. Specimens of urine passed in my presence and also specimens brought for examination showed the urine to contain an uniformly diffused hemorrhage of a dark color. Examination of the urethra, bladder and prostate proved negative. Kidneys could not be palpated. Diagnosis: Passive congestion of the kidney, due to obstructive cardiac lesion. Patient was ordered to have inunctions of mercury, and protoiodide of mercury internally. This had a happy effect as long as the treatment was carried out; but the patient was indifferent and as soon as the hematuria began to clear he would discontinue treatment. Patient passed from under my observation eight months ago.

5. Active Hyperaemia of Prostate. History similar to vesical calculus. Case referred by Dr. J. M. Goldsmith. Mr. A. F. McD., age 19; nativity, Florida; occupation, clerk. Father died of acute Bright's at 49. No venereal history. Began to notice blood clots in urine one year ago. Activity increased the number of urinations. Seldom felt the urgency of urination at night. Occasional backache. Once or twice he noted urination was suddenly arrested. Had pain in region of perineum now and then. Pain always followed urination, lasting two or three minutes. Exercise increased pain; rest lessened it. Hemorrhage only present in third glass test. Residual urine ounces 1. Physical examination: Kidneys could not be palpated; pain absent over bladder; no hemorrhoids. Had previously been treated for cystitis through error of diagnosis. Was examined with stone searcher, but no stone present. Palpation of prostate per rectum, showed a moderately enlarged and tender prostate. Cystoscopy disclosed a large, bulging prostate, acutely congested, also thick mucus. Ureteral openings: Normal. Prostate was massaged and ex-



pression contents examined, which were largely composed of thick, viscid mucus and red blood cells. Treatment: Gentle massage of prostate twice weekly, alternating with full size Guyon sounds, and bladder irrigated with nitrate of silver, 1 to 4,000, gradually increasing to 1 to 500. All symptoms subsided in three weeks. Has had no treatment for past four months; neither has there been any return of symptoms.

6. Pedunculated Papilloma of Prostatic Urethra. Mr. J. D. B., age, 30. Case referred to our genito-urinary clinic by Dr. E. M. McDonald, November 23, 1908. Patient began to notice pain in lower lumbar region 3 years ago, which was followed by frequent micturitions, 12 to 15 times daily. Two and a half months ago he began to pass a slight amount of blood with first flow of urine. Palpation of prostate showed it slightly enlarged and tender with a few nodules. No history of gonorrhoea. No median bar. Examination of prostatic urethra with a Goldschmidt's irrigating posterior urethroscope disclosed, to Dr. Bryant and myself, a pedunculated papilloma about the size of a pea, situated just to the left of the verumontanum. I photographed this papilloma with a photographing urethroscope and hope to show you the negative later. Patient is to return shortly when we propose removing the tumor with a snare or the actual cautery.

#### NOTES.

Presumptive evidence of:

1. Vesical or renal hemorrhage.
2. Tumors of kidney.
3. Rest amounts to nothing in renal hemorrhage.
4. Neck of bladder, hypertrophied prostate and vesical calculus.
5. Renal.\*
6. Prostatic.
7. Villous tumors of the bladder. Solution of adrenalin, aluminum sulphate, etc., when introduced into the bladder will not check renal hemorrhage.
8. Urethra.
9. Neuroses of bladder.
10. Vesical calculus and prostatitis.
11. Posterior urethritis, or cystitis.
12. The bladder capacity remaining intact, this is presum-

tive evidence of diabetes mellitus, diabetes insipidus, chronic interstitial nephritis, and urina spastica.

13. Patients with stone, as a rule, sleep all night without having to void their urine.

14. Hypertrophied prostate of chronic prostatitis.

15. The pain of renal colic occurs on the side corresponding to the diseased kidney and radiates along the ureter down into the groin or testicle.

16. Spasmodic pains and affections of bladder.

17. Urethral stricture—pain at sight of obstruction.

Bibliography: Ayers, Cabot, Casper, Christian, Erichsen and Lydston.

928-929 Candler Building.

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\*The rule that "the darker and more diffuse the blood is, the more renal source." Fenwick states, should absolutely be rejected.

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## REPORT OF THREE CASES OF EMPYEMA.

BY CHAS. P. WARD, M. D., ATLANTA, GA.

The radical procedure in Empyema is resection. If extensive adhesions of pleura are present they are broken up—even Estlander's operation may be deemed necessary.

The methods of aspiration and irrigation that bear a relation to the method used in the cases to be reported are Potain's syphon tubes. Bulan's method, Hulton's duck-bill drainage and Pertlie's aspirator and air-pump. These devices are used to prevent the entrance of air to the pleural cavity, to preserve the integrity of the chest wall, and allow the lung to assume its normal position, if free. The irrigation of the pleural cavity, after resection is advocated by Parker, Bealz, Fernelt, Tanfilief, Lavaschaff and John Wyeth. Wyeth uses bichloride 1-1,00 to 1-3,000; Tanfilief used normal saline solution in ten cases, with rapid recovery and final cure in all. Zeman irrigated by submerging the patient in a bath of sterile water—the acts of respiration washing out the cavity.

Wm. Ewart, Samuel West and Edmund Anders advise the use of drainage first.

Any procedure that admits air to the pleural cavity may cause serious embarrassment or death, due to pleural apoplexy, shock or collapse of the lung.

The method used in the following cases differs from any I have been able to find in the literature at my disposal, and it was evolved to meet indications in the first case.

The apparatus consists of an aspirator, a fountain syringe or irrigator, a glass "Y", or a Kashimoura's thoracic trocar in order to see that the solution is free of air, stiff tubing for connections, trocar and canula—a hot water bath (103 to 110 degrees) through which the irrigating tube passes in order to prevent chilling of the pleura—also suitable solutions for irrigating.

To one side of the "Y" the aspirator is attached, to the other side, the irrigator. The stem of the "Y" is fitted with a short piece of stiff rubber tubing that fits snugly over the canula. With the apparatus thus equipped the trocar and canula is inserted at point of election into the pleural cavity. The trocar is now withdrawn, a finger is placed over the opening in the canula to prevent entrance of air until the tube on the stem of the "Y" can be attached to the canula. Now allow suction, and if the fluid is present let the water from the irrigator flow through the "Y" into the aspirator in order to remove any air that might be present. Cut off the solution and continue mild suction of the pus until the fluid stops, or the patient shows signs of distress. Cut off suction and allow solution to flow into the chest until the quantity withdrawn is replaced, again cut off solution and allow suction till symptoms indicate the need of refilling the chest. Repeat this procedure till the wash water comes away clear—this of course if the patient stands the ordeal well.

The advantages of this procedure are: (1) In case of collapse, hot water can immediately be thrown into the chest. (2) It admits no air to the cavity during the process of irrigation. (3) The suction induced favors the descent of the lung, while in resections the atmospheric pressure is liable to cause collapse of this organ. (4) The preservation of the chest wall, for following resections there is always more or less distortion thereby encroaching upon the normal capacity of the lung. (5) This can be done under local anaesthesia, a decided advantage as such cases do not take a general anaesthetic well.

**Case 1.**—Charles R., age 24, family history and previous history negative.

Present history, January 15th, had pneumonia of three weeks' duration. This was followed by slow fever, weakness, loss of appetite, pains in right side, especially on taking a deep breath. This continued with cough most of the time difficulty in breathing. A diagnosis of tuberculosis was made in April. The above condition continued till June 1st, when patient began to grow worse rapidly, complaining of "stuffiness" in his right side. The cough became almost incessant, with scant expectoration—loss of weight, inability to sleep and great weakness. I first saw patient on June 15, 1906. Temperature 104; respiration 50 to 60. The right chest was bulging and the nipple area showed redness. Percussion gave flatness over entire side which extended beyond the spine on left side at base of lung.

Ansultation—Vesicular murmur absent except tubular breathing over larger bronchi which were forced high up into the apex. Diagnosis—Empyema. Immediate aspiration drew off two full quarts of pus. Next day patient was brought to city for operation and 60 oz. drawn away. This was followed by a chill with temperature 101 to 105. On June 20th, one quart was removed before introducing any solutions and I estimate that fully one pint came away with the wash water. The apparatus did not work so well this time because of a too soft tube which would collapse at sterile, normal saline solution leaving 24 to 30 oz. in the chest. at this time. On the 24th I aspirated again drawing off 24 oz. pus before irrigating. The patient being stronger I washed the chest thoroughly with 3 quarts bi-chloride 1-4,000, followed by 3 quarts sterile, normal saline solution leaving 24 to 30 oz. in the chest. There was in this water fully 20 oz. of pus making about 13 or 14 pints of pus from this case in 11 days.

The patient improved rapidly under tonics and food, and the fluid was gradually absorbed.

In April, 1907, physical examination showed normal respiration over entire lung—a few bands of adhesion and thickening of pleura. This man is sound today with no evidence of ever having had this trouble.

**Case 2.**—Miss S. W. L., age 30. Family history negative. She nursed an aunt 65 years of age said to have bronchitis. Pre-

vious history—Had cough with pain in left side about a year ago, attack lasted several months. Had coughed occasionally since.

Present history.—About January 1st, 1907, she was exposed to cold with recurrence of pain in side and cough. No expectoration, general malaise and loss of appetite. I first saw patient January 19. Temperature 103, pulse 120 weak. History of having had fever for over a week. Examination of chest revealed friction sounds over posterior scapular space and around to nipple line—otherwise negative. Tongue was coated, bowels constipated, headache in the evening and some distention over abdomen. Her temperature ranged from 101 to 104 during the next eight days. At the end of this time physical examination showed fluid in left chest extending to eighth rib scapular line. Put patient on iodides, with restricted fluids. Temperature still continued typical typhoid or septic course. Six days later physical examination showed increased effusion, and aspiration advised. On February 5th I drew off 12 oz. sero-purulent fluid before irrigating with 1-8,000 bi-chloride followed by 3 quarts saline solution leaving about 10 oz. in cavity. I estimate 24 cz. of sero-purulent fluid in this case—negative by culture. The sputum showed positive T. B. Temperature declined and was normal on fifth day—the fluid disappeared and patient was able to return to her home in the mountains February 25th, but her convalescence was slow. She grew very weak during that summer and sputum showed active T. B. Case followed, and following result reported by letter from her on February 1st, 1909. Patient went to Asheville, N. C., and took tuberculin, remaining there for six months. She returned to Asheville last summer, and at present weighs 145 lbs.—more than ever before. She believes that the continued tuberculin immunity will prove a cure for her.

Case 3.—Mrs. F. M. Y., age 45. Family history obscure. Previous history—has had "womb trouble" for years.

On March 28, 1907, patient brought to my office from home in Florida—said to have hopeless tuberculosis. She was on her way to North Georgia to die, so she said. She gave history of pain in right side with cough for past 3 months. Temperature 100, pulse 112; respiration 34. Examination indicated fluid. I aspirated three days later and drew off 30 oz. sero-purulent fluid which was negative microscopically and by culture. Irrigated thoroughly as in the other cases, leaving about 10 oz. of saline

## ORIGINAL COMMUNICATIONS.

in the chest. Estimated 12 oz. fluid to have come away with water. Patient made rapid recovery, fluid being rapidly absorbed. On third day temperature and pulse normal and eight days after operation she was carried home much improved. I have seen this case three times since finding the vesicular murmur over entire lung with few friction rales indicating some pleural adhesions.

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### CLINICAL NOTES ON GONORRHEAL CASES TREATED WITH SERUM.

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While a large number of cases of gonorrhea are successfully treated in a comparatively short time without complications, it also happens that quite a large percentage of all cases are complicated by complications such as prostatitis, epididymitis, urethritis and arthritis. All of these complications are serious and prone to successfully resist all forms of treatment. These cases especially are difficult to treat successfully and in these patients become crippled or bed-ridden. Any treatment which is based upon rational theories and appears to have hopes of successful treatment, merits consideration.

Rogers and Torrey call the attention of the profession to Antigonococcic Serum in articles appearing in the Journal of the A. M. A., for January 27, 1906 and September 14, 1906. This serum is prepared from the blood of rams that have been treated with gradually increasing doses of both dead and live virulent strains of gonococci. The rams are treated until they are immune and the process of preparing the serum from them is essentially the same as that of preparing antidiphtheria and antitetanic serums. A quantity of this serum, which was placed in my hands for clinical experimentation, I have used in the treatment of 18 cases on male patients; four private patients in the Dispensary of the College of Physicians and Surgeons. Detailed histories of these cases would be of no particular

but as a contribution to the literature on the subject I offer the following resume of the results of the clinical study of this serum:

There were three cases of posterior urethritis which received a total of 12 injections with the result that one was promptly cured, one showed considerable improvement and one was unimproved.

Four cases of epididymitis received a total of 10 injections: one was cured, two improved and one unimproved.

Four cases of prostatitis received a total of 7 injections; 2 were decidedly improved and 2 unimproved.

Seven cases of gonorrheal rheumatism received a total of 22 injections; 2 were cured; 2 were improved and 3 unimproved.

The dose given at each injection was the contents of one bulb of 2 ccs. of serum. This was repeated at intervals of one to four days, controlled by the clinical symptoms. The injection was made deep into the muscular tissues.

A recapitulation of the 18 cases treated is as follows:

Four (or 22 1-2 per cent.) were cured.

Seven (or 38 1-2 per cent.) were improved.

Seven (or 38 1-2 per cent.) were unimproved.

718 North Howard street.

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## ACUTE TRAUMATIC TETANUS TREATED BY MAGNESIUM SULPHATE. (continued).

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WITH REPORT OF A CASE IN THE TREATMENT OF WHICH INJECTION OF AN AQUEOUS 25 PER CENT. SOL. OF MAGNESIUM SULPHATE WERE MADE IN THE SPINAL SUBARACHNOID SPACE; WITH RECOVERY.

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We used magnesium sulphate, in the method stated above, in our case, and the results were so surprising and so satisfactory

that we feel justified in urging its use in tetanus. It is important that the utility and the value of this drug as an agent to control the tonic and clonic muscular contractions so characteristic of this disease be exactly determined. Its value must be decided by the combined experience of clinicians the world over.

Cases of tetanus in the Treatment of which subarachnoid injections of an aqueous solution of magnesium sulphate have been employed:

1. Blake, Jos. A. Male, 15 years, 115 pounds. The use of magnesium sulphate in the production of anaesthesia and in the treatment of tetanus. Surgery, Gynecol. and Obst., Chicago, 1906, vol. II, p. 541.

Period of incubation. Previous immunization. Nature of wound.—Seven days. None. Crushed first three fingers of left hand.

Other Treatment.—Antiseptic disinfection of wound. On 3rd day of disease (10th of injury) 40 cm. of antitetanic serum injected in spinal cord between 4th and 5th cervical vertebrae. 20 c. c. injected in median cephalic vein. On night of same day 20 c. c. injected in media nbasilic vein. On 11th day after injury, 35 c. c. of antitetanic serum injected in spinal canal by lumbar puncture. Chloral hydrate and morphine given when patient not under the effect of magnesium sulphate.

Magnesium Sulphate Treatment.—On the 12th day of injury intra-spinal injection of 4.5 c. c. of magnesium sulphate (25 in 100 of water). 33 hours later repeated injection. 37 1-2 hours later intraspinal injection 8 c. c. of a 12 1-2 per cent. solution of magnesium sulphate. 27 hours later repeated above injection. Six days after repeated same injection.

Result.—Recovery.

Comments.—Injections have a marked effect in restraining the convulsions and relieving pain, thereby conserving strength and preventing excess metabolism and heat production.

2.—Markoe, F. H. Male, 4 years, 40 pounds. Reference same as case 1, p. 549.

Period of incubation. Previous immunization. Nature of wound.—Seven days. None. Sloughing wound of skin and subcutaneous tissue of the right leg.

Other Treatment.—Four injections each of 5 c. c. of anti-tetanine serum were injected into buttock, the external jugular



vein, the spinal canal, and back respectively. Occasional doses of morphine and chloral.

**Magnesium Sulphate Treatment.**—1.5 c. c. of a 25 per cent solution of magnesium sulphate were slowly injected into the subarachnoid space.

**Result.**—Died 28 hours after first symptom of disease appeared.

**Comments.**—Death cannot be attributed in the slightest degree to the magnesium sulphate. On autopsy cultures of tetanus bacillus were obtained from the wound, spleen, and heart blood, showing a marked tetanus bacteriaemia.

3.—Logan, Samuel. Male, 11 years, 80 pounds. The treatment of tetanus by intra-spinal injections of magnesium sulphate for the control of convulsions. Jour. A. M. A. 1906, vol. XLVI, p. 1502.

Period of incubation. Previous immunization. Nature of wound.—Eight days. None. Gunshot wound of hand with old toy pistol loaded with blank cartridge.

**Other Treatment.**—Simple cleansing of wound after development of the disease. On day of admission 50 c. c. of antitetanic serum injected intra-spinally. Chloral hydrate, gr. 15, sodium bromide, gr. 30, every 4 hours. On 3rd day after admission 10 c. c. antitetanic serum injected in each brachial plexus, in each sciatic nerve, and into the tissues around wound, in all 50 c. c.

**Magnesium Sulphate Treatment.**—On 3rd day after admission general anaesthesia. 4 c. c. of a 25 per cent. solution of magnesium sulphate injected in spinal canal by lumbar puncture. On 4th day again gave patient general anaesthesia and injection in subarachnoid space by lumbar puncture, 50 minims of 25 per cent. solution magnesium sulphate.

**Result.**—Death 40 hours and 50 minutes after 1st injection of magnesium sulphate. Heart failed before respirations affected.

**Comments.**—Temperature 108.2 F. per rectum. Complete cessation of muscular convulsions followed introduction of magnesium sulphate.

4.—Logan, Samuel. Female, 24 years. Reference same as above.

Period of incubation. Previous immunization. Nature of wound.—Seventeen days. None. Vaccination.

**Other Treatment.**—100 c. c. of antitetanic serum injected subcutaneously. 30 hours after appearance of first symptom, wide excision of vaccination wound, and dusting of surface with dried antitetanine serum.

**Magnesium Sulphate Treatment.**—30 hours after first symptoms were noticed 4 c. c. of a sterile 25 per cent. solution of magnesium sulphate were injected into spinal subarachnoid space by lumbar puncture. Local anaesthetic employed. 17 1-2 hours later injection was repeated.

**Result.**—Death 50 hours after appearance of first symptoms.

**Comments.**—No good resulted from the use of the magnesium sulphate solution. Patient was moribund when 2nd injection of magnesium sulphate was made.

5.—Franke, Morgan. Male, 32 years. Ein Fall von tetanus behandelt mit intra duralem injectionen von magnesium sulphuricum. Zentral. fuer Innere Medicin, 1907, vol. XXVIII, p. 344.

Period of incubation. Previous immunization. Nature of wound.—Twelve days. None. Wound on the middle finger.

**Other Treatment.**—Energetic antiseptic handling of wound is recommended by this author. Amputation of finger. Chloral hydrate, gr. 30 per rectum daily.

**Magnesium Sulphate Treatment.**—19 days after infliction of injury, intradural injection of 1 c. c. of sterilized 25 per cent. solution of magnesium sulphate. 5 days after above intradural injection of 2 c. c. of same solution. 4 days later repeated same injection. Injecting needle broke in tissues. Removed by operation.

**Result.**—Recovery.

**Comments.**—Franke noticed after each injection of magnesium sulphate that there was a lessening of contracture, also noticed that the injections exerted a beneficial action on the muscular convulsions. Sleep was better. Nourishment possible.

6.—Robinson, Canby G. Male, 11 years, 67 1-2 Pounds. Treatment of tetanus by intraspinal injections of magnesium sulphate. Jour. Am. Med. Assn., 1907, vol. XLIX, p. 493.

Period of incubation. Previous immunization. Nature of wound.—Contusion of scalp. None. Played considerably around stable.

**Other Treatment.**—Excised supposed wound of entrance.

Chloral hydrate, gr. 30, sodium bromide, gr. 60, every 24 hours for the first two weeks.

**Magnesium Sulphate Treatment.**—On the 11th day of the disease, patient was anaesthetized. Ethyl chloride used as a general anaesthetic. 3 c. c. of a 25 per cent. solution of magnesium sulphate injected in subarachnoid space. On the next day repeated injection using 3 1-2 c. c. On 15th day of disease injected in same locality 4 c. c. of same solution.

**Result.—Recovery.**

**Comments.**—Author states that the intraspinal injections of magnesium sulphate produced marked lessening of the very severe symptoms for a number of hours. The muscular rigidity was never so severe after each injection as it had been before.

7.—Meltzer, S. J., and Auer, Jno. Male, 35 years. *The Journal of Experimental Medicine*, 1906, vol. VII, p. 705.

Period of incubation. Previous immunization. Nature of wound.—Four days. Insignificant wound of foot which healed rapidly.

**Other Treatment.**—Large doses of antitetanine serum and sedatives gave no relief. 2 hours before death, an intravenous injection of antitoxine serum was given.

**Magnesium Sulphate Treatment.**—One intraspinal injection of magnesium sulphate 1 c. c. to every 18 pounds of body weight.

**Result.**—Death 5 hours after injection of magnesium sulphate solution in subarachnoid space.

**Comments.**—Anaesthetizing and relaxing effect complete. Respiration good to end.

8.—Miller, Robert. Male, 7 years, 60 pounds. Treatment of tetanus with subarachnoid injections of magnesium sulphate. *The Am. Jour. of the Med. Sciences*, 1908, vol. CXXXVI, p. 781.

Period of incubation. Previous immunization. Nature of wound.—Seven days. None. Lacerated wound of left hand.

**Other Treatment.**—Antitoxin daily for 14 doses varying from 1,500 to 7,000 units. Sedatives for a short time. Copious saline enemas and infusion.

**Magnesium Sulphate Treatment.**—Eleven lumbar punctures made within 13 days. Approximately 25 c. c. of a 25 per cent. solution of magnesium sulphate being injected into the meninges at each puncture.

**Result.—Recovery.**

Comments.—“Of the value of the treatment by magnesium sulphate, no one who witnessed this case has any doubt.” The muscular paralysis following each injection lasted from 18 to 29 hours. It involved all muscles, except those of head, neck and diaphragm. The injections were followed several times by respiratory collapse lasting 11 to 14 hours and the pulse dropped, though not to a dangerous degree.

9.—Henry, Jno. Norman. Male, 9 years. *International Clinics*, 1908, Series 18, vol. IV, p. 1. Case I.

Period of incubation. Previous immunization. Nature of wound.—Six weeks. None. Abrasion of skin of back by kick of horse.

Magnesium Sulphate Treatment.—Lumbar puncture 3 c. c. of 25 per cent. solution of magnesium sulphate injected in subarachnoid space. 5 days later subarachnoid injection repeated.

Result.—Recovery.

Comments.—The case was a severe one. Made an excellent recovery. Each injection was followed by a relaxation of the rigidity.

Case II.—Male, 19 years, 123 1-2 pounds.

Period of incubation. Previous immunization. Nature of wound.—Seven days. None. Stepped on a nail. At time of admission, the wound was healed.

Other Treatment.—Wound of foot excised.

Magnesium Sulphate Treatment.—Lumbar puncture 6 c. c. of sterile solution of magnesium sulphate injected into spinal canal. Ethyl chloride used as anaesthetic.

Result.—Death admitted July 30th, died August 2nd.

Comments.—One hour after injection patient was entirely relaxed. A rise of temperature followed the intraspinal injection.

Case III.—Male, colored, 9 years, 55 pounds.

Period of incubation. Previous immunization. Nature of wound.—Six days. None. Stepped on nails with both feet and inflicted punctured wounds.

Magnesium Sulphate Treatment.—Lumbar puncture, 4 c. c. of clear spinal fluid withdrawn. 2 1-2 c. c. of 25 per cent. solution magnesium sulphate injected into spinal canal. Two days later repeated injection, only gave 2 c. c. at second injection.

Result.—Death.

Comments.—A rise of temperature followed each injection.

Case IV.—Male, 45 years.

Period of incubation. Previous immunization. Nature of wound.—Three weeks. None. Stepped on nail.

Other Treatment.—On same day as second subarachnoid injection, 18 c. c. of antitetanus serum were given subcutaneously. On the morrow, 30 c. c. of antitetanic serum were injected into the left buttock.

Magnesium Sulphate Treatment.—6 c. c. of 25 per cent. solution of magnesium sulphate injected into subarachnoid space by lumbar puncture. 3 days after above, performed lumbar puncture, removed 35 c. c. of clear spinal fluid, and injected 6 c. c. of solution of magnesium sulphate.

Result.—Death on evening of 2nd day following injection.

Comments.—“It is very much a question whether the magnesium sulphate did not contribute to the patient's death.”

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SOME EXPERIENCES IN SURGERY OF THE APPENDIX WITH REPORT OF CASES.

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BY R. R. KIME, M. D., ATLANTA, GA.  
GYNECOLOGIST AND ABDOMINAL SURGEON TO TABELL  
INFIRMARY.

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There is nothing more uncertain than the findings of the appendix. Its position, structure, and relations of the abdominal and pelvic cavities as well as bone and muscular structures account for the varied conditions and complications that arise in connection with the appendix.

We shall not endeavor in this paper to mention or describe the varied conditions, complications and sequelae of the appendix, but simply present a few of the interesting conditions lately encountered in our surgical work.



Case 1.—Tubular appendicitis with complete destruction of the appendix—Mrs. B., age 30 years, widow, husband died 4 or 5 years previous of pulmonary tuberculosis.

Patient has had several attacks of pain in right inguinal region—of late more or less constant pain, tenderness, indigestion and loss in weight with induration and enlargement in right side.

Operation at Tabernacle Infirmary, November, 1907. Incision at border rt. rectus muscle. Adhesions of omentum separated a portion 3 by 4 inches removed, adhesion of small intestine separated a thickened indurated point cleansed with hydrogen-dioxide—pure carbolic acid applied, then neutralized with alcohol followed with salt solution, the surface closed over with catgut suture.

At end of caecum appendix obliterated—a mass two by two and one-half inches the thickened degenerated wall of the intestine was curetted off. Hydrogen-Dioxide applied followed with carbolic acid pure neutralized with alcohol and salt solution. Surface closed over with catgut sutures, incision closed by layer sutures of catgut and Murphy fig. 8—black silk worm gut suture. Pathologist reported tuberculosis. Patient made uninterrupted recovery rapidly gained in health and flesh and has since remained in good health.

Case 2.—Atrophy or obliterating appendicitis—movable rt. kidney—nephritis, dysmenorrhoea, anteflexed uterus.

Miss B. from North Georgia, age 24 years, injured in a runaway accident six months previous, being thrown from buggy. Pain and tenderness of rt. kidney and in region of appendix and rt. ovary. Hyaline gran. casts, round ep. in urine, no alb. Operation July, 1908 at Tabernacle Infirmary. Incision one-half inch below 12th rib. Decapsulated and stitched up rt. kidney, dilated and curetted uterus, incision made transverse in angle of flexion and closed longitudinal with uterus, then abdomen was opened at border rt. rectus muscle. Rt. ovary resected and after considerable search appendix was found very little over one inch in length and one-third the normal diameter and very little meso-appendix. The appendix was removed and abdominal incision closed with catgut and fig. 8 silk worm gut suture. There was some little infection from knots of chronic catgut in kidney incision otherwise patient made a good recovery. Her mother made special request not to remove appendix because five of the

immediate family had died from appendicitis, two with and three without operation.

Case 3.—Chronic appendicitis, general tenderness of bowels and obstinate constipation, indigestion. With tonics and medicine to improve digestion, large doses of laxatives all tenderness would disappear to return as soon as bowels became constipated.

When worse gran. and hyaline casts, kidney epithelium and large amounts of indican were found in urine. Was living with sister who has a severe attack of pulmonary tuberculosis.

Patient, Mr. G., age 24 years, single. Operated, December, 1908 at Tabernacle Infirmary. Incision—muscle splitting method, omentum, caecum and appendix inflamed, concretion in tip of appendix retrocaecal, meso appendix short—in stitching and tying off, had free bleeding, extravasation of blood under peritoneal covering forming small hematoma controlled by lateral lapping and stitching, abdominal incision closed with layer cat gut sutures. About one week after operation one or two glands became inflamed in left inguinal region but soon subsided.

Patient is gaining rapidly and has gone to the country to rest and recuperate. A late letter states that he is doing well and gaining flesh rapidly.

Case 4.—Long Retro—caecal appendix—no meso appendix—concretion in tip.

Miss G., age 23 years, subject to attacks of rheumatism, marked retroversion of uterus, dysmenorrhoea, confined to bed at times. Tenderness in right and left Morris points and McBurney point, right kidney movable 1st degree and tender granular epithelial and hyaline casts, rd. ep. and some indican in urine. Regulation of diet giving bitter tonics, intestinal and renal anti-septics with mild alkaline diuretics kidney function very much improved. Operation December, 1908 at Tabernacle Infirmary. Cervix dilated, uterus curetted, median incision in abdomen, both ovaries resected, both round ligaments with anterior layer of broad ligaments plicated anteriorly method of Coffee, appendix could not be brought up about 5 inches long retrocaecal without meso-appendix had to be separated from caecum commencing at tip in which was a concretion size of grape seed, stump treated in usual manner, appendix and caecum congested, abdominal incision closed with layer cat gut and figure 8 silk worm gut suture.

Patient made a good recovery and kidney lesion clearing up.

Case 5.—Appendicitis due to oxyuris vermicularis (thread-worm).

Patient, F. C., boy, age 10 years. Taken with pain in right inguinal region a. m. of May 15, 1908. Dr. Brawner saw case at 7:30 p. m.—Diagnosed appendicitis. I was called at 8:30 p. m.

Patient was transferred to Wesley Memorial Hospital and appendix removed before 10 p. m., by muscle splitting operation.

Appendix four or five times normal size, badly inflamed, ready to necrose, was occluded at caecal end and contained several thread-worms.

Aether pneumonia developed within 48 hours, which under appropriate treatment soon subsided. The coughing produced a little irritation of incision, otherwise patient made uneventful recovery.

Case 6.—Mrs. S., age 24 years, married, one child 10 months old—first attack of appendicitis—seven days duration was better, temperature and pulse nearly normal, grew worse in the afternoon. Dr. Vaughn, the attending physician was called and recognized a marked change for the worse. I was called, found patient with temperature 100 F., pulse 140, weak—no special pain, some rigidity muscles right side, bowels distended, some tenderness, anxious expression, advised immediate operation. Hypodermic of hyoscine and morphine given at 8:30 p. m., patient moved at once in elevated position to Tabernacle Infirmary.

Incision in right iliac region—abscess not ruptured, peritoneal cavity packed off with gauze—abscess opened and drained with rubber tubes, gauze wick in one, soiled pads removed and light gauze packing placed to protect peritoneal cavity from abscess drainage, appendix not found—operation and dressing consumed 15 minutes. Fecal fistula followed, surfaces sloughed from irritating discharge. Fistula closed, wound healed, no hernia, patient well and has regained usual weight.

Case 7.—Mr. B., age 46, weight 225 pounds. First attack of appendicitis about one year previous. Second attack November 3, 1908. A. M. Doctor called P. M.—gave hypodermic of rest medicine. Dr. W. T. Jones called next A. M., and I saw patient about 11 A. M. Pulse about 78. Temperature 98.8 F., no pain, no special rigidity, tongue slightly furred—we advised operation, but patient refused, said he would go to business next day he was feeling so well.

Feeling there was serious danger in this case, physician, Dr. Jones called again in a few hours with pulse above 100, temperature nearly 104, indicating any pain and no rigidity of muscles.

I was called again at 5 P. M. We both operated. After considerable persuasion patient was given hyposcine 1-100 gr. morphine, 1-4 gr. at once and moved to Tabernacle Infirmary in a room two squares away. The pain returned shortly, was tonic and became intense before anaesthetic was begged for it, to get relief from the severe pain in right inguinal region, muscle splitting method, peritoneal fluid escaped as soon as abdomen was opened, adherent but easily separated. Caecum bound down by adhesions from previous attack, appendix retrocaecal adhesions found three gangrenous spots in terminal ileum, appendix could not be brought up into incision, so applied two long clamps to terminal ileum, placed three large drainage tubes, two retrocaecal side of pelvis and wound dressed, provisional sutures being introduced.

Hypodermoclast used, patient placed to bed, morphine and Murphy's proctoclysis used for 36 hours.

Next A. M. when nurse and intern were on duty, patient got out of bed and walked across room to urinal, catheter.

Forceps loosened in 36 hours, removed in 48 hours, discharge present tissues sloughed from discharge, granulating and filling up in two weeks, but by some way, temperature and pulse ran up, sloughed, large dose quinine in rectum 10 to 20 c. c. antipyretic daily and supporting treatment, trouble with cal fistula closed, no hernia, made good recovery, regained usual weight. This patient was once treated by Sir Joseph Lister for injury to left leg, which was stiff and interfered with handling patient in the hospital.

The thick abdominal walls and excessive adhesions interfered with healing process.

In the last two cases the provisional silk sutures that were introduced at operation could not be

account of severity of infection, fecal discharge and sloughing, being compelled to have free drainage to save life of patients.

In the last few years Ochsner, Murphy and Fowler have given us life saving measures in handling these desperate cases. The knowledge of the absorptive powers and motion of the peritoneum being least in the pelvis, greatest at the diaphragm has demonstrated the great value of the Fowler's position. Ochsner's demonstration that food or fluids in stomach set up peristaltic action of bowels proves the necessity of not feeding or filling stomach in cases of appendicitis and at times may necessitate washing out stomach with stomach tube. Murphy's phenomenal success in the treatment of fulminating peritonitis has demonstrated the value of the relief of tension, free drainage and flushing the tissues by procto-clysis. A minimum amount of work, a maximum amount of drainage without flushing out of abdomen spreading infection, or mopping out to produce traumatism.

Every surgeon should familiarize himself with Murphy's method of proctoclysis in order to use it properly and effectively. He states that "next to the conservative technique of the operative procedure, proctoclysis is second in importance as a life-saver. It rapidly restores blood pressure, it improves capillary circulation, it quiets the thirst, it eliminates the septic products and increases the excretions. All the details are simple, but they must be carried out with precision to secure the best results."

Murphy also urges the necessity of keeping this class of patients in Fowler's position before and after operation and as much so during operation as possible and while being conveyed to the hospital.

The method of treating the stump of the appendix has resulted in death in some instances from hemorrhage so that some surgeons now advise ligating stump in all cases where possible to do so. I have been as I believe obviating that danger by an extra bite or turn of the purse-string suture, forming a loop surrounding base of meso-appendix including arterial blood supply to appendix, so that when suture is tied the blood supply will be constricted.

In pelvic surgery in the female we are often confronted with the necessity to decide whether to remove or not to remove the appendix.

This will always be a question of personal equation and the wish of the patient.

Where the appendix is diseased and condition of patient will admit there should be no question as to removal.

I always get consent of patient to remove appendix if diseased. I have in some cases refused to operate without such consent where I felt it was likely to be found diseased.

Where appendix is not diseased so far as we can tell and patient prefers not to have it removed or where the vital powers of patient have been severely taxed with other operative work and appendix not specially at fault, I leave it. There is one point in this connection that must not be entirely ignored and that is where we have a diseased appendix leucocytosis exists or nature develops local fortifications or barriers against infection and it is less danger then to remove the appendix than in normal conditions where no increased resistance has been developed.

This brings up the subject of leucocytosis with polynuclear increase or leucopenia as indications and contra-indications for operative work and as an index to the vitality or resisting powers of the patient in combatting infection. Much good work is being done along this line and gives promise of good results when the findings are coupled with the clinical history of the case. The future will demonstrate its limitations and value, with more definite rules for guidance if it is to be of practical value in every day work.

Case 1 in this report was one of tubercular degeneration of the appendix involving intestine and omentum by removal of a part of the diseased structures and disinfecting the remains, the recovery was complete and has remained so up to this time. The tubercular condition was probably contracted from husband who died previously of tuberculosis.

The third case was probably a commencing tubercular involvement of a previously irritated and diseased appendix, the condition of the caecum omentum, the lymphatic, extravasation of blood in operating, the general tenderness of abdomen, loss of flesh and living with sister who has pulmonary tuberculosis tend to confirm such a diagnosis.

Case two was one of early atrophy or want of development of appendix being only 24 years of age, it was not a senile change.

It was more interesting because of so many deaths of relatives due to appendicitis.

Case four illustrates a more common condition of retrocecal appendix without meso-appendix more difficult to remove, at times requiring transfixing base first then separating upward, concretions being common in such cases.

Case five illustrates the unusual condition of appendicitis due to thread worms, also its rapid dangerous development without previous indication or warning.

Cases six and seven illustrate what can be done in desperate cases by prompt action and utilizing the important principles of treatment advocated by Ochsner, Fowler and Murphy.

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## SEX EDUCATION.

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BY FOLLEN CABOT, M. D., NEW YORK.

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The need of educating the public in matters relating to diseases contracted both through sexual and chance contact, is to my mind a very great one.

The vast amount of ignorance in such matters is appalling and unbelievable.

The responsibility in the matter rests largely with physicians. We must keep in the van and by preventive measures diminish the ravages of these relentless diseases. What has been done to awaken the minds of people to the dangers and proper care of tuberculosis can also be done in so-called sexual disorders. Here, however, owing to the nature of these diseases, the progress toward enlightenment is necessarily slow. The majority of those afflicted have become so through ignorance. Behind the scene stands the all-powerful sex instinct which often acts regardless of consequences. This must always be so as long as life endures, but I believe by the spread of simple truths, much unnecessary suffering may be prevented.

The entering wedge to the problem, it seems to me, is through early education in matters relating to sex.

The youth of the world must learn about this important part

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of life, therefore it is better that they should learn to do so in a simple, wholesome way from their parents.

In hospital work during the last ten years, I have been endeavoring to instruct patients about sexual diseases. Leaflets and other ways have, I think, made some progress. Several other hospitals besides the Post Graduate have been doing this work. We, of course cannot say from year to year how much progress has been made, but I feel sure it is one of the most effective ways to educate the public.

Boards of Health will eventually treat these diseases as they do other contagious diseases. Public opinion will do the rest.

The fact that these diseases are spread by contact is already, in my opinion, sufficient reason for some state action.

In addition to the leaflets on Gonorrhoea and Syphilis, we have added the following one on the problem of sexual diseases and dangers of ignorance.

DANGER IN IGNORANCE—SOME AXIOMS OF HEALTH.

1.—Sexual relations are not necessary to keep in good health.

2.—If not made use of the power does not become weak.

3.—In those men who don't live an active sexual life, nocturnal emissions (wet dreams) each week or two are normal and can do no harm.

4.—The dangers of serious disease are always avoided by marriage.

5.—If disease is contracted it often does permanent damage not only to the man, but to his future wife and children.

6.—A man or woman may be badly diseased and still live.

7.—To avoid these dangers, physical exercise in the open air and out of doors gives healthy relief.

8.—In boys and young men growth of mind and body progresses better without this relation.

9.—To avoid sexual thoughts train the mind by studying clean books.

10.—Avoid drinking, obscene pictures and vice. Smoking in moderation is beneficial. Choose clean and respect womanhood.

N. B.—By following the above common sense rules a man will remain strong sexually, keep his body clean and his own and other's happiness.



## GLASS DRAINAGE TUBES IN PROSTATIC SURGERY.

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BY FOLLEN CABOT, M. D., NEW YORK.

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The problem of drainage in surgery of the prostate is a very important one. Many methods of draining the bladder after prostatectomy have been employed.

I have never been satisfied with rubber drainage tubes. They are difficult to keep in place, and are generally, to my mind, unsatisfactory. The more closely we can observe prostatic cases the better; therefore it occurred to me that glass could be used to great advantage for this purpose. The tube I am about to describe is one made for me by Tieman & Co. I here refer to tubes for use in suprapubic work.

The tube is a double current glass tube of about 35 French scale bent at a right angle. The bladder end is about four inches long and has a large eye near the end. Running up from the eye on the outside is a small glass tube made as a part of the large one. This follows the large tube straight up and does not curve. It projects an inch or trifle more above the right angle turn. The outer part of larger tube is 2 1-2 inches long, and points towards the patient's pubic region. This double flow tube may be held in place by adhesive plaster or bandage with hole cut for entrance of small tube.

On each outlet we place rubber tubing, and if we so desire, we can have a constant flow of solution in at small tube, out at large one. The flow can be closely watched. The tube is always clean and held securely in place. The distance it projects into the bladder may be increased or decreased by padding of gauze under external arm of tube.

It is well to have two or three sizes of these tubes.

In the two steps operation, preliminary cystotomy and secondary prostatectomy, we can very easily find the best position for the tube after the cystotomy and continue it after the prostatectomy.

I have used these tubes in several cases and they have been very much more satisfactory than any I have ever tried before.

New York, 129 E. 31st street.

# EDITORIALS

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## THE PERSONAL EQUATION.

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"The proper study of mankind is man."—Pope.

Just now, while the followers of Paul Dubois, Ellwooster and Mrs. Eddy are indulging in polemics, that make the sparks and the fur fly, the thoughtful physician may find from this wilderness of words a valuable harvest.

Our many and excellent medical colleges can equip the graduates for the practice of medicine with theories galore; can hold out to him the lamp of knowledge, glowing from the accumulated stores of centuries of the midnight oil; but, unless he reads some of those "Sermons in storied halls," unless he deals with the sick he exercises that homely trait, called the late Joe Brown "judgment," he can never hope to excel in his profession.

The common paraphrase from Saint Paul's words "meat for babies and meat for strong men," may well be a part of our everyday life.

The laity are reading now as never before. Studies of various phases of psychological research are being furnished by enterprising periodicals in a form attractive and easily understood, while the various cults, each claiming to have discovered a new and basic principle, find no difficulty in reaching the public.

Not so very many years ago, when a doctor was called to his remedies were taken without question, and his *ipse dixit*

sufficient reason for the procedure set in motion. The whys and wherefores did not interest the patient, so long as relief was obtained.

Many of the most charming pictures drawn by novelists have portrayed the family physician, secure in the confidence, respect and love of his clientele; whose statements admitted no argument, whose decisions were appealed to no higher court.

Some of those old worthies possessed not a tithe of the scientific attainments held by our present-day medical lights, but they, in their spheres, wielded an influence almost autocratic in its power.

Then that other strong type, the general practitioner, (who it is freely predicted will soon be as extinct as the dodo) with his intimate acquaintanceship in his community, marks the antithesis of that ultra sect, who regards sick people as so many human units, to be judged by their qualities of tissue-resistance.

Far be it from me to decry any of the modern means of diagnosis or treatment. We surely need them all. Nor would I minimize the inestimable value of the labors of Virchow, Pasteur, Metchnikoff, Wright and others, that host of unselfish investigators, to whom the world owes so much.

What I plead for is a greater consideration for the personal equation, and with it the *temperament*, that climate of the mind, as it is called by Weir Mitchell.

When we can tap the hidden springs in our patients' emotions; locate the jarring elements of personality, probably making up a part of some vicious circle; when we can make the sufferers feel that they are getting not only adequate medical treatment, but in addition a sincere study of their individualities, our influence for good will be greatly strengthened, and the gratifying results will abundantly justify our efforts.

In considering idiosyncrasies of body, let us also seek for those of thought. In bolstering up weaknesses of functions, let us not neglect weaknesses of will power. In stimulating the flagging energies of vital organs, let us not forget that discouragement or disappointed ambition may be a causative factor of importance. Most of all let us, as far as consistent with the truth, ring a note of hope and good cheer with every prescription, with every word of advice.

Thus, in deeper study of the human side of those who come to us in their infirmities, whether real or imaginary, we can more fully measure up to what is required of the medical profession, command greater confidence from the public at large, and render unprofitable the calling of these healers, who promise so much, and who fail entirely to realize that "A little learning is a dangerous thing."

G. M. N.

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### SOME SUGGESTIONS REGARDING APPLICATION OF THE ROSE BELT.

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In the February issue of the *Journal-Record* the writer indulged in some remarks concerning gastropptosis in tubercular patients, but did not attempt to give any treatment for this condition.

The general management of gastropptosis, with the frequent accompanying ptoses of the other abdominal viscera, is a broad subject—too broad to be adequately described here.

This downward mal-position, being to a great extent caused by atony, the principal and rational means of correcting it would be mechanically supportive, and many forms of support have been advocated and used with more or less success.

Several years ago Dr. Achilles Rose, of New York, began using a special form of adhesive plaster made on moleskin, and applied with an upward pull to the lower abdomen, his ideas and methods being very fully brought out in an inexpensive little monograph entitled "*Atonia Gastrica*," by Rose and Kemp, and published by Funk & Wagnalls Co., 1905.

The technic of applying this belt is fairly well described also in Conheim's late book on the digestive canal. There are, however, some modifications devised later by Drs. Robert Kemp and Theodorus Bailey, of New York, which give greatly improved results.

Both Conheim and Dr. Rose himself, in an article appearing in the *Medical Fortnightly*, of March 25th, portray the belt being applied while the patient is standing erect. Dr. Kemp, in putting it on, requires the patient to lie down, while Dr. Bailey goes further, elevating the hips six or more inches, thereby facilitating

the gravitation of the ptosed organs into the upper part of the abdominal cavity. This permits the belt to be fitted on more snugly and effectively.

Any physician, who has been accustomed to placing this belt in position with the patient standing, will find that, while it entails a little more time and care to get it smoothly fitted with the patient recumbent and the hips elevated, the satisfactory results obtained will easily justify the increased efforts.

The writer wishes, therefore, to commend to the profession the desirability of correcting by the use of this belt, whenever possible, the various atonic ptoses of the abdominal viscera, for often it will be found that, with these in proper place, a long train of perplexing symptoms will either disappear, or be markedly improved.

G. M. N.

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#### RESOLUTIONS ON THE DEATH OF DR. C. C. STOCKARD.

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One by one our co-workers answer the Final Roll Call and lay down their armor in peace to enter the Life beyond. Dr. Charles Cecil Stockard, our friend and professional brother, answered that summons in the full fruition of his professional life and usefulness.

To know him was to love and respect him.

He was a true Christian physician, believing not only in the spiritual life beyond, but also in living that life here, proving true to his church, his family, his professional brethren and to suffering humanity.

He did much to establish an ethical, legitimate, professional basis of the treatment of the drug habitue and inebriate.

Dr. Stockard was one of the pioneers in the establishment of a private sanitarium or infirmary in the city of Atlanta, owning and operating one at the time of his death. As a small token of our regard and esteem, be it

Resolved, That in the death of Dr. C. C. Stockard, the Fulton County Medical Society has suffered a material loss, the profession and humanity a tried and true friend. That we extend to his widow and family our sincere sympathy and sorrow.

That a copy of this report be spread upon the minutes, a copy be sent to Mrs. Stockard and that it be published in the daily papers.

Respectfully submitted,

R. R. KIME,  
W. L. CHAMPION,  
L. C. FISCHER.

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RESOLUTIONS OF SYMPATHY FROM THE FULTON  
COUNTY MEDICAL SOCIETY TO THE WIFE AND  
LOVED ONES OF DOCTOR WILLIAM  
BUCKINGHAM ARMSTRONG.

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Since the Wise and Omnipotent Father has seen fit to remove from among us Doctor William B. Armstrong, be it resolved by the members of this society that we have sustained an irreparable loss in the death of our beloved friend, whom we had learned to so love and esteem, and that we extend to his wife and family our deepest and most heartfelt sympathy.

Be it further resolved, That we know words are both lacking and inadequate for the expression of our feelings in so sad an hour, and that the loss of our friend, a noble gentleman, a skillful surgeon and one who was ever eager to lend a helping hand to the afflicted and suffering, can only be compensated for in the solace that He who was "a Man of Sorrow and acquainted with grief" directs our lives for the best and good of all.

Be it further resolved, That copies of these resolutions be sent to the wife and the mother of Dr. Armstrong, be spread on the minutes of this society and be published in the daily papers.

C. R. ANDREWS,  
A. W. STIRLING,  
J. H. JOHNS.

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RESOLUTIONS ON THE DEATH OF DR. W. B. ARM-  
STRONG, BOARD OF THE GRADY HOSPITAL.

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Whereas, God in His wisdom has seen fit to remove from our Board our beloved friend and professional brother, Dr. W. B. Armstrong, and

Whereas, In his death we have lost a friend and colleague who by his noble life has not only endeared himself to us but to the profession and the people whom he served, and

Whereas, This Hospital has lost an able surgeon and true friend:

Whereas, That a page in our Minutes be set aside to the memory of this modest, unassuming gentleman, whose loss has caused us inexpressible grief.

Resolved, That our deepest sympathy be tendered to the various members of his family in this time of their affliction.

Signed,

W. A. CROW,  
W. S. GOLDSMITH,  
C. W. STRICKLER.

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## NEWS AND NOTES

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The Seventh District Medical Society held its third annual session at Marietta, Ga., March 10, 1909. The following are the officers: President, R. P. Cox, M. D., Rome, Ga.; vice-president, C. F. McLain, Calhoun, Ga.; Secretary and treasurer, H. L. Erwin, Dalton, Ga.

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At a recent meeting of the Board of Trustees of Grady Hospital, the following physicians were elected: Dr. G. P. Huguley, assistant to Dr. J. C. Olmsted; Dr. F. G. Hodgson, assistant to Dr. Willis Jones; Dr. Archibald Smith, assistant to Dr. Geo. H. Noble; and Dr. W. E. Yankey, assistant to Dr. L. C. Fischer, Dr. Westmoreland was elected surgeon to succeed Dr. W. B. Armstrong, deceased.

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The medical class of 1879 of the Atlanta Medical College, gathered at the Piedmont hotel March 5th at a banquet tendered them by Dr. H. B. Stewart, of Fountain Inn, S. C. Dr. W. S. Elkin, Dr. Willis Westmoreland and Dr. O. W. Calhoun were

invited. The others present at the dinner were: Dr. J. L. Selman, Douglasville; Dr. W. J. Adair, of Rockmart; Dr. R. H. Taylor, of Griffin; Dr. B. F. Braselton, of Weatherford, Tex.; Dr. W. J. Chapman, of Inman, S. C.; Dr. J. M. Spinks, of Rockmart; Dr. H. D. Allen, of Milledgeville, and Dr. H. B. Stewart, of Fountain Inn, S. C.

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The department of agriculture has received complaint as to the existence of glanders among the horses and mules in certain portions of Monroe county, and fears are expressed that the disease will spread, causing the death of much valuable stock.

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Mrs. William K. Vanderbilt, Sr., has given more than \$1,000,-000 for the erection of four modern tenements for persons suffering with tuberculosis. The buildings are to be operated in connection with Dr. Henry L. Shively's tuberculosis clinic, of the Presbyterian hospital, and are to be known as the Shively Sanitary Tenements. A moderate rental will be charged tenants.

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#### SAVING DOCTORS.

Knicker—"There are plenty of books telling how to save life while waiting for the doctor."

Bocker—"Yes. What we need is one telling the young doctor how to save life while waiting for the patient."—*Harper's Bazar*.

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#### REGULAR MEETING FULTON COUNTY MEDICAL SOCIETY, CARNEGIE LIBRARY, FEBRUARY 18, AT 8 P. M.

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REPORTED BY R. R. DALY, M. D.

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Dr. Strickler, the president, presiding.

Dr. Roy read his paper upon "Lachrymal Stenosis in Children."

Dr. Stirling said he had seen several cases of infantile stenosis and epiphora, all of which recovered under massage, collyria and expectant treatment. He never had to operate in any way. He told of an absence of one canaliculus in an adult. The slitting



and probing are to be avoided as a rule and used only after every other means have been exhausted. Sometimes he passes a hollow needle into the duct and injects through it what he requires. This leaves no scar or deformity. In old chronic cases of epiphora, he advocates the removal of the tear sac.

Dr. Daly said his experience had been along the line of massage rather than operation in children. The expectant treatment was aided frequently by completion of development of the parts.

Dr. Roy, in closing, said he hoped to interest the obstetrician in the subject so that the natural worry of the mother might be relieved by the assurance that the child would get well.

He believes that most of the cases are due to lack of development.

Dr. Kime gave an interesting paper upon "Some Experiences in Surgery of the Appendix and Report of Cases." This paper appears elsewhere in *The Journal-Record*.

Dr. Willis Jones said in discussion that only about a fourth of his cases showed the appendix in normal position and with normal peritoneal covering. He asked Dr. Kime's experience in this regard.

In a recent tubercular case, he found great pain and considerable pus with disintegration of the appendix. Case died. There was no temperature, but high pulse.

Another case had violent pain at appendix, high pulse and no temperature. He hasn't had as good fortune as Dr. Kime.

Dr. Davis congratulated Dr. Kime upon his success with serious and complicated cases and regrets that his own experience has not been so gratifying. He commented upon the injudicious use of purgatives because of the increased peristaltic wave they set up may cause rupture in lower part of intestine.

Dr. Hardin complimented Dr. Kime upon his paper and his successful surgery in getting his cases operated upon early. He thinks that turning patients flat on abdomen in transit to the hospital is better than Fowler's position, as well as after operation.

Dr. Kime in closing said that he believes Fowler's the better position because the secretions are kept away from the diaphragm which part of the peritoneum absorbs poisons more readily.

Dr. Visanska reported a case of lobar pneumonia in 6 year old child with hyperaesthesia of the diaphragm and stiffness of neck and hips. The diagnosis was obscure at first.

Another child had suspected trouble in the appendix, but developed posterior pneumonia on right side.

Another case, 17 months old, presented diphtheria with no special constitutional symptoms. It seemed a little sick and he looked in the throat only as a matter of routine. The membrane was entirely upon posterior pharyngeal wall, and not on tonsils or pillars at all. He suggests that the toxins were not absorbed because of the smaller lymphatic supply to the part involved, this accounting for lack of constitutional symptoms.

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MEETING FULTON COUNTY MEDICAL SOCIETY  
HELD AT CARNEGIE LIBRARY, MARCH 3, 1909.

Dr. Strickler, president, in the chair.

Dr. Amster read an interesting paper upon "The Diagnostic Value of Test Meals in Gastro-Intestinal Diseases."

Dr. Andrews said in discussing it, that many of the tests are not so easy as the essayist stated. The Schmidt and Strasburger diet and test take considerable time, often lasting several days. The value of test meals depend upon whether they have been thoroughly cooked. Muscular fibre is very differently manifested in the stools when its surrounding tissue has been so broken up by cooking as to allow the digestive processes to go on from the same fibre when it is ingested partly cooked or raw.

Fermentative tests have to be made for undigested starch and biologic examinations are necessary to determine the intestinal flora. Too much importance cannot be placed upon this subject and if the tests are too quickly or only partially made, valuable information is lost and the conclusions may be misleading.

As to occult blood great care is necessary to prevent small haemorrhoids giving it in the stools or irritation of the stomach tube causing it to appear in the gastric contents from the injured gums or throat.

Dr. Niles said that many patients had such a horror of the stomach tube that whenever he could, he gave a retention meal and then palpation was made in 3 1-2 hours. If a gurgle or splash resulted, it meant myasthenia.

He called special attention to attempting through subjective methods to diagnose hyperacidity. The burning sensations do not always mean too much acid by any means.

Accurate methods should be employed to prevent grave error. Too much bi-carbonate of soda is given anyway.

Dr. Amster said in closing that his paper was intended to be of clinical value and not an attempt to go exhaustively into scientific tests. When he used the quick methods and advised them, he meant to find by them the right track upon which to pursue such further examinations as were indicated. He wished to stimulate everyone to make such examinations before completing a diagnosis and beginning a treatment.

Dr. McRae spoke on the subject of "Prostatectomy."

Dr. Ballenger said that there was reasonable ground for the advocacy and choice of both the supra-pubic and the perineal methods; the large adenomatous glands are better removed above while small ones come more readily from below. As a preliminary operation, he frequently procures supra-pubic drainage by thrusting in a large trocar and canula, (as advocated by Belfield) introducing a soft catheter through the canula and then removing the canula, leaving the catheter in place. This drains the bladder until the conditions improve and the patient is better able to stand the operation.

Dr. Willis Jones agrees with Dr. McRae that the operation should always be done to save constant catheter life and be done as early as this condition seemed imminent. The supra-pubic method seems to have from two to three times the mortality of the sub-pubic, but its results are better when recovery occurs. There is no pain on sitting and the urethra is in far better condition.

Dr. Hancock suggested the dividing the operation into two sittings. He suggests the anæsthetic may be the cause of death.

Dr. Goldsmith described Dr. Young's methods and says it is marvelous to see him extract the gland through the perinaeum even with the aid of his special tractors and retractors. Young has a high table so that the operative field is directly before him where he doesn't need to bend and tire himself to see what he is doing. Dr. Goldsmith exhibited a prostate he had removed the previous day. The first part of the operation was sub-pubic and only a small part of the gland could be secured. He thought he had enough to give relief. A few hours later, the patient was in greatest distress, totally unable to void urine. He hastily went

down supra-pubically and removed a mass five times as large as the entire gland. Relief was complete and the patient is doing well.

Dr. McRae in closing says that all the worst cases are done by the supra-pubic method which doubtless accounts for much of its apparently greater mortality.

The anaesthetic should be gas-oxygen and even then there is trouble in getting complete relaxation.

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MEETING FULTON COUNTY MEDICAL SOCIETY  
HELD AT CARNEGIE LIBRARY, MARCH 18,  
AT 8 O'CLOCK

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Dr. Strickler, the president, presiding.

Dr. Phinzy Calhoun presented a case of cystic degeneration of the lachrymal sac that had caused exophthalmus and partial loss of vision due probably to neuritis. Several years before, large polypi had been removed from each naris. They recurred and were removed again a few weeks ago.

The operation for the cyst consisted in opening at the eyebrow and shelling out the tumor which fortunately came easily. The recovery was rapid.

Dr. Kime exhibited a large multilocular cyst removed from woman 79 years old. Passed change of life at 48. Had 12 children, youngest 32, no miscarriage. First enlargement of cyst came 8 months ago. Previous to operation, palpation at different parts of the abdomen had shown different degrees of density. The fluid, nearly three gallons was drawn from the cyst under different degrees of pressure. The Mayos advised removal of the cyst entirely because about 4 per cent. of those drained first, are followed by cancer. Dr. Kime preferred draining in this instance because of the danger of collapse if the large growth were suddenly lifted from the abdominal vessels.

Dr. Baird read his paper on "Acute Lobar Pneumonia," which appears elsewhere in the *Journal*.

Dr. Duncan said he agreed almost completely with the essayist, but would proceed with caution in the use of phenacetine and all the coal tar derivatives. He wants to use veratrum in young and robust subjects and usually combines it with some opiate. He always uses quinine, dover's powder or capsecum. He agrees that

glycerine and clay that "comes in cans" is of no use. Sometimes sinapisms and jackets are good especially where there is pleuritis. He doubts the value of the general use of whiskey.

Dr. Roberts said that the line of treatment should be considered from three standpoints:

- 1.—That of cough and infection.
- 2.—That of symptoms of essential fever.
- 3.—That of the cause.

We don't know enough of why the germs cause the condition to enable us to attack the activity successfully in that way. We must use the knowledge we have of the essential fever as it shows its activities in our experience and treat along that line. It is manifestly a disease of obstructed circulation with all that applies and we must give our aid and stimulation to relieving the obstruction and increasing the force of the circulatory apparatus.

Dr. Baird in closing laid stress again upon the value of phenacetine and said that its intelligent use by the careful clinician was attended with no danger whatsoever. Two grains every 2 to 4 hours was his dosing and he watched this. The heat itself we know to degenerate muscular and nervous tissues and that the heart suffers in both these ways from high temperature. High temperature does not destroy the germs except by injuring the patient and we as physicians have no right to stand by and let the battle rage in our patient's body. Phenacetine will reduce fever. It will give the patient comfort and rest and will assist him in recovering. Whether it has any effects upon the toxins he doesn't know. He confidently expects that in the next decade, there will be such advances in biology as to give us knowledge of the germ life, the propagation of its toxins and a suitable means for combatting their evil effects.

Dr. P. Calhoun read an exhaustive and interesting paper upon the "Present Status of the Ophthalmic-Tuberculin Reaction of Calmette."

Statistics for and against this method of diagnosis were presented together with the recently expressed opinions of many eminent ophthalmologists sent to the writer. His conclusions were that it might have some value but should never be given except in an eye one was sure of being normal. He would use it himself in such cases. It has no ophthalmological value.

Dr. Lokey said he has been treating several cases lately in

connection with the family doctor and is not satisfied with the reaction. It is not decisive. The statistics in America are not reliable in his judgment because we don't hear of the unfavorable cases. Among the negroes and the Russian Jews we get an over-positive reaction because, doubtless, of the ill nourished condition of many of these people.

Dr. Paullin spoke at length upon the method of securing the tuberculin. It is a question in any injection as to whether we are using a potent toxine. There is no standard of judging toxicity. Koch's old tuberculin may vary 100 per cent. in the rabbit test and this takes several days to accomplish. He is not opposed to the skilled use of tuberculin.

Dr. Wheeler is opposed to the use of uncertain and sometimes dangerous method of examination. He sees nothing to be gained by it.

Dr. Daly said that the clinical methods of examination were so much better than they used to be that one could rely confidently upon them and the laboratory assistance without endangering an eye with what often proved harmful. He had recently seen two eyes badly inflamed by the Calmette injection. He would not introduce it into his own eye if he suspected tuberculosis, but would prefer to wait and keep his eyes in good order even if he had the disease. If he did not have it the eyes were never endangered.

Dr. Gaines said that the reaction is so doubtful that we are no better off in diagnosis than we were before Calmette gave out his theory. The general practitioner doesn't pretend to be sure an eye is normal and then many of his cases do not have normal eyes and other methods must be used. The best clinicians are coming back to the hypodermatic plan so far as tuberculin is concerned. There the doses can be graduated carefully, the temperature noted and the presence or absence of moist rales at the primary foci be determined. In this clinical way, diagnosis may be assured.

Dr. Ballenger said he had introduced the tuberculin into the urethra instead of the eye as here it is less likely to do harm and is yet in touch with mucous membrane. The reaction when gained is slight irritation as if the urine were concentrated and a slight redness at the meatus.

Dr. Calhoun said he was in no sense an advocate for the meth-

od, but wanted to present the matter to the society in all its phases.

Dr. Kime told of administering to a man 70 years old 1-100 grain of scopolamine and 1-8 grain of morphine at 3 o'clock. At 6 o'clock there was active delirium, the man insisting upon getting out of bed. He gave 5 drops of veratrum hypodermacally and catheterized the patient. In an hour he was quiet. Dr. Kime asked if others had had any similar experience with the small amount of scopolamine.

Dr. Sellman said that he used the drug frequently as a preliminary to anaesthesia and sometimes, there was muttering delirium but nothing active.

Dr. Willis Jones reported a case of stone in the kidney. The patient was a woman 21, married and with two children.

All her life she had had recurring attacks of pain in the right side of the abdomen, frequently accompanied with haematuria, sometimes lasting several days.

Ten days ago her family doctor said he could feel and hear stone in the kidney. Dr. Jones was called in and doubted the doctor's statement till he himself heard the crepitation. The haemorrhage after manipulation was profuse. Strangely enough the lady's chief pleasures which were horseback riding and skating never caused her either distress or haematuria.

Four days ago, he operated and removed some six or eight large calculi which he exhibited. He had heard them sliding upon each other in the kidney under manipulation. They were of different formation, some were phosphatic and others uric acid deposits.

Dr. J. L. Campbell related a case of prostatic colic if one will admit the term. A man had several attacks of pain recurring in right side of prostate. On palpation a good sized lump appeared where it might be an enlarged seminal vesicle. The manipulation amounted to massage. Patient was told to bring sample of urine next morning. He appeared at that time and presented a small stone about the size of a grain of wheat which he said he had passed through the urethra. The prostate trouble at once disappeared and patient made a perfect recovery. This calculus probably stopped one of the seminal ducts and was dislodged by massage.

# BOOK REVIEWS

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**WOMAN.** A Treatise on the Normal and Pathological Emotions of Feminine Love. By Bernard S. Talmy, M. D., Gynecologist to the Yorkville Hospital and Dispensary, former Pathologist to the Mothers' and Babies' Hospital, etc., New York. For Physicians and Students of Medicine, with 23 drawings. Fourth enlarged and revised edition. Published by the Practitioners' Publishing Co., New York.

Rarely now-a-days do books fill what may be truly said to be a "long felt want;" occasionally such is the case and "Woman" has proved that it falls in the class of such works by the call for new editions every few months.

Talmy has made a careful study of this intricate subject and has presented to the public a clear, concise account of this little-discussed yet important subject. Many homes have doubtless been wrecked by the ignorance of physicians, who when consulted regarding these matters, could not deal with them in a scientific manner.

The book is divided into 8 parts which are devoted to the following subjects: I Introduction, II Evolution of Sex, II Anatomy of the Genitals, IV Physiology, V Pathology, VI Hygiene, VII Psychology, VIII Morality.

The spirit in which this book is written removes from it the smutty or vulgar interpretations that might be placed upon a subject of such delicate nature. A clear understanding of woman is necessary for all physicians and we commend to them this book.

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**BACTERIAL FOOD POISONING.** A concise exposition of the etiology, bacteriology, pathology, symptomatology, prophylaxis, and treatment of so-called ptomaine poisoning. By Prof. Dr. A. Dieudonne, Munich. Translated and edited, with additions, by Dr. Charles F. Boldouan, Bacteriologist, Research Laboratory, Department of Health, City of New York. Authorized translation. Published by E. B. Treat & Co., New York. Price \$1.00.

This practical little book should prove of great value to health



officers who are so often called upon to investigate poisoning by food. The favorable reception of the original work by Dieudonne made the success of a translation almost certain; Boldouan has well performed his task as editor and has incorporated additional outbreaks of food poisoning and has adopted the work to American conditions.

Much greater importance is now placed upon the bacterial nature of these poisons than formerly when they were thought to be due to "ptomaines." We can cheerfully recommend the work to all who are interested in such subjects.

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**ORTHOPEDIC SURGERY FOR PRACTITIONERS.** By Henry Long Taylor, M. D., Prof. of Orthopedic Surgery and Attending Orthopedic Surgeon, New York Post-Graduate Medical School and Hospital; Assistant Surgeon, Hospital for the Ruptured and Crippled, New York. Assisted by Charles Ogilvy, M. D., Adjunct Prof. of Orthopedic Surgery, New York Post-Graduate Medical School and Hospital etc., and by Fred H. Albee, M. D., Instructor in Orthopedic Surgery, New York Post-Graduate Medical School and Hospital, New York. With 254 illustrations. D. Appleton & Co., New York, Publishers.

Taylor has succeeded remarkably well in carrying out his plan of presenting this subject in a form suitable for the general practitioner, who sees, oftener than the specialist, the crippling affections in their incipiency when perhaps comparatively simple methods of treatment may save many from deformity or death.

The work is divided into general, special and technical parts; this arrangement economizes space, emphasizes the importance of underlying causes and is more convenient for reference. In the general part in which the underlying principles are discussed the reviewer looked for reference to the excellent work on intestinal proteid putrefaction which has been done by Hoke and Andrews, but failed to find any mention of the possibility of such a cause for certain forms of rheumatism. That this is a fundamental cause of many joint affections has been clearly demonstrated by curing the patients by proper regulation of diet and bowels, with results, at times, quite remarkable.

Taylor has had twenty-five years' experience in orthopedic work and in his book gives the gist of it to the practitioner in an

interesting and attractive form. The book is beautifully printed and well bound, and the illustrations are good, most of them having been taken especially for this work.

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TRANSACTIONS OF TENTH ANNUAL MEETING OF  
THE AMERICAN PRACTOLOGIC SOCIETY. Edited  
by Samuel T. Earle, M. D., and Lewis H. Adler, Jr., M.  
D.

This volume contains the papers and discussions read at the 1908 meeting of the society, together with a list of its members and a note as to the date of its organization, as well as a list of the meeting places and of its officers from the inception of its organization to the present time.

Many excellent contributions to rectal surgery are contained in this book, by many of the foremost men in America.

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CLINICAL DIAGNOSIS AND TREATMENT OF DISOR-  
DERS OF THE BLADDER. With Technique of Cystos-  
copy. By Follen Cabot, M. D., Prof. of Genito-Urinary  
Diseases, Post-Graduate Medical School; Attending Geni-  
to-Urinary Surgeon, City and Post-Graduate Hospitals,  
New York, Illustrated. Published by E. B. Treat & Co.,  
New York. 8 vo. 225 pages, prepaid \$2.00.

This well written little volume on diseases of the bladder by Cabot affords the practitioner a clear and safe guide in the management of these disorders. The extensive clinical experience and the careful work done by the author well qualify him to write the book we have under review. Attention is given to case recording, management of the patient and the methods of examination necessary to elicit the facts required for the diagnosis.

Especial attention is appropriately given to cystoscopy, but other useful methods of diagnosis have also been discussed. The book is fairly well illustrated and is well printed and bound.

E. G. B.

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APPENDICITIS and Other Diseases of the Vermiform Appen-  
dix. By Howard A. Kelly, M. D., with 215 original illus-  
trations, some in colors and three lithographic plates. Pub-  
lished by J. B. Lippincott Co., Philadelphia. \$6.00 net.

So excellent have been the previous contributions to medical

literature by Howard Kelly that we have come to look upon his work as among the best that we have the pleasure of reviewing. This monograph on the appendix is fully up to the standard set by Kelly's other books, and will long remain a storehouse from which surgeons may acquire the most reliable information upon this important and widely studied organ. The graphic illustrations by Miss Ruth Huntington, now Mrs. Max Brodel, deserve especial commendation, as also do the printing and binding by these well known publishers.

Kelly lays much stress on promptitude in operating, and urges that time be not lost by dawdling when the necessity for operation is clearly recognized; golden moments may be lost and result in a fatal result when prompt action would have saved the patient's life.

Much attention is devoted to pathology, clinical history, treatment previous to operation, operative treatment, and care of the patient after operation and post-operative sequelae.

The earliest definite anatomical record of disease of the appendix appears to have been made by Lawrence Heister in 1711 and reported in 1755; the first reported cases of appendicitis observed during life is the one of Mestivier in 1759.

The general excellence of this work justifies its recommendation without reservation, as its teachings are safe, thorough and attractively presented.

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**COSMETIC SURGERY.** The correction of featural imperfections. By. Charles C. Miller, M. D., Second Edition Enlarged.

Including the description of numerous operations for improving the appearance of the face. 160 pages. 96 illustrations. Prepaid \$1.50. Published by the author, 70 State street, Chicago.







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U. HOLZER  
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